7-29-2019 11:00 AM

The Role of Child Protection Services in Preventing Child and Adult Domestic Homicides: Missed Opportunities and Barriers to Change

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Graduate Program in Education
A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy

Abstract

This dissertation involves three studies exploring the risks children face living with domestic violence (DV) and the critical role of child protection services (CPS) in assessing risk in DV cases. The first study examined the involvement of CPS prior to domestic homicide cases as reviewed by the Ontario Domestic Violence Death Review Committee (DVDRC). One in five of the homicide cases where children were present in the family system had prior involvement with CPS. The underlying themes of DVDRC recommendations directed to the child welfare sector highlighted the need for enhanced ongoing services to promote safety and hold perpetrators accountable, specialized DV training, and increased cross-sector collaboration. Findings emphasized the need for continued efforts to develop community awareness and collaborations to assess and manage risk.

Study two utilized data from an online survey of 138 Ontario child protection workers (CPWs) on their risk assessment and safety planning practices with DV cases. Assessing and managing risk was frequently and consistently completed across the province; however, the specific strategies and identified challenges varied. CPWs mostly utilized CPS mandatory tools to assess risk. Some CPWs added their clinical judgment or use of other standardized DV risk assessment tools, based on training and experience with DV cases. Emphasis was placed on consistently working collaboratively with families and professionals in other sectors to address risk.

Study three built on the survey in study two through in-depth interviews with 29 Ontario CPWs to examine their perspectives on assessing risk with families where DV is the primary concern. CPWs identified numerous barriers at the systemic (i.e., challenges with

collaboration), organizational (i.e., lack of written policies or procedures specific to DV), and individual (i.e., worker-client relationship barriers, high caseloads, lack of ongoing training) levels. Encouragingly, some CPWs identified a diverse range of promising practices in overcoming barriers and engaging with victims and perpetrators.

Overall, the findings from these studies suggest that child protection can play a key role in assessing and responding to risk factors related to serious harm or homicide. There are multiple warning signs that should trigger CPS involvement to collaboratively manage risk. CPS can be a more effective part of an overall coordinated community response that promotes awareness, specialized training, assessment tools, and intervention strategies for high-risk DV cases that threaten the lives of parents and children.

Keywords

Domestic violence, domestic homicide, child homicide, child protection services, death reviews, risk assessment, risk management, safety planning

Lay Summary

This dissertation consists of three studies that looked at dangers children face living with domestic violence (DV) and the key role of child protection services (CPS) in understanding the dangers present in DV cases. The first study was a case analysis looking at any involvement of CPS that happened before the DV-related homicides. These cases came from a database from by the Ontario Domestic Violence Death Review Committee (DVDRC). One in five of the homicide cases where children were in the family system had prior involvement with CPS. The DVDRC recommendations directed to the child welfare sector highlighted the need for better ongoing services to promote safety for victims and children and hold perpetrators responsible for their violence, more DV training for workers, and better relationships between different services that help families. Findings emphasized the need for continued efforts to develop community awareness to understand and reduce danger.

Study two utilized data from an online survey of 138 Ontario child protection workers (CPWs) on the ways in which they gather information and make decisions with the family about risk and keeping everyone safe when there is DV. These strategies to keep families safe were often completed across the province; however, workers worked differently and faced difficulties. CPWs mostly used the CPS required tools to look at dangers. Some CPWs added their prior knowledge or used other DV questionnaires, based on training and experience with DV cases. CPWs discussed the importance of building relationships with families and other professionals in order to help reduce the dangers for children.

Study three built on the survey in study two through in-depth interviews with 29 Ontario CPWs to look more closely at how they work with families where DV is a big issue and making it unsafe for children. CPWs identified numerous barriers at the systemic (i.e.,

challenges with working together with other professionals), workplace (i.e., lack of written rules or steps that need to be taken that were specific to DV), and individual (i.e., worker-client relationship barriers, high caseloads, lack of ongoing training) levels. Encouragingly, some CPWs identified a diverse range of ways to work through these barriers and be effefctive with victims and perpetrators.

Overall, the findings from these studies suggest that child protection can play a key role in considering and responding to dangers that can exist when DV is happening. related. There are many dangerous behaviours that should alert CPS to meet with the family and other professionals to reduce risk. CPS can be a more effective part of an overall coordinated community response that promotes awareness, specialized training, assessment tools, and intervention strategies for high-risk DV cases that threaten the lives of parents and children.

Acknowledgments

During the course of my graduate studies, I have had the privilege of working with a number of people to whom I am indebted for their mentorship, support and collaboration. In addition to those who have contributed guidance and input in terms of my research, several people have also provided the support, encouragement and friendship that made this long road an enjoyable one. It takes a village to raise a Ph.D. and I was very lucky to have been surrounded by many people who helped me cross the finish line.

First, and foremost, I extend deep gratitude to my advisor, Dr. Peter Jaffe, for being the best 'coach' during the marathon that is writing a dissertation. Peter, your dedication and passion to ending violence against women and children is remarkable. It has been an honour to learn from you for so many years and you have taught me more than I can give you credit for here. Even when I felt like someone who couldn't cut the mustard, you pushed me to put the pedal to the medal and not bite off more than I could chew in order to forge ahead. You were there at the drop of a hat to provide constructive feedback and encouragement. Your humour is the bee's knees and appreciation for a good idiom was always the icing on the cake. The lessons I have learned from you will stay with me as I journey onwards and upwards.

I am indebted to my advisory and examination committee members, Drs. Claire Crooks, Jason Brown Jacquie Specht, Wendy Ellis and Angelique Jenney, who read, critiqued, and contributed their expertise at various stages of the research process. Your insights, constructive feedback, and support were invaluable. A special thank-you to Drs. Linda Baker and Deb Chiodo for taking the time and effort to help in the preparations for my thesis defense – it was incredibly helpful in easing my worried mind.

I am incredibly grateful to have been a part of a research centre throughout my time at Western. To the amazing staff and team of researchers at the Centre for Research and Education on Violence Against Women and Children (Barb M., Anna-Lee, Linda, Barb P., Maly, Elsa, Dianne, Jassamine, Sara, Marcie and countless other students) for your encouragement and collaboration you have provided me during my graduate studies. Your kindness, passion, brilliance, and dedication to gathering and disseminating knowledge to

ending violence against women and children is unparalled. I know CREVAWC will continue to make significant contributions to making the world a safer place for all. I would like to thank Mike Saxton for his support and input on the research contained in this dissertation. Our research has often been conducted in parallel and I can't imagine a better thesis buddy. Mike, you have been a source of great collaboration and discussion of both research issues & life's follies, but above all else, friendship and laughter.

A special shout-out to my hilarious, immensely dedicated, inspiring, kind, and brilliant cohort of future psychologists. It has been a privilege to walk alongside all of you and I feel so lucky that happenstance put us together in our graduate studies. I look forward to continue learning from, and laughing with, each of you.

I am grateful for my friends and family who have always supported me over the years. To my LDs for their always appreciated humour, love, and loyalty. To Brittany, for her incredible patience and extra-ordinary support as I worked through many challenges, and for always being there to celebrate in my successes.

Thank you to Michael, Marcus, and Gina for their encouragement, witty jokes, and always reminding me of the importance of humility. Marcus and Gina, I especially thank you for bringing one of the great sources of joy into my life, Alice Sylvia, during this journey. Thanks also to Rene, Rod, and Siva for their enthuasism and encouragement in the last stages of my journey.

To my parents, for their unwavering support in always pushing me to do my best and demonstrating what it means to work hard. To my dad, for showing me the importance of showing up and keeping a commitment. You have always (albeit sometimes begrudgingly) been dedicated to the work you set out to do and to make sure our family has what we need. To my mom: my touchstone and source of inspiration for many of my clinical and academic endeavours. Many years ago, you brought me into your professional world of helpers, academics, and social justice activitists and I just never left. Growing up, I watched your compassionate heart work in tandem with your brilliant mind to help, and fight, to make our community a better place for the most vulnerable children. Among the many things I have learned from you, perhaps the most profound has been watching you carry out the simple act

of showing up for and tuning in to others. Mom and dad, I love you both and I thank you for everything you have done.

To Ranjit, who came into my life at the hardest and final stages of my dissertation and never hesitated to come along for the ride. Your love and steadfast support made the most difficult part of this journey brighter and better. I thank you for your encouragement, for being so very understanding (especially when I needed to GSD), and that you wished for my dissertation to be finished on your 33rd birthday. Your thoughtfulness, combined with your dedication and commitment to helping others, makes you the best of what humans can be and you continue to inspire me every day. I love you and I look forward to our future adventures together.

Finally, I would like to thank the participants of this study for their time, effort, and candor in sharing their experiences of working in the challenging field of child welfare. And to the victims and survivors of violence and tragedy. May we never forget the importance of the continued efforts to create safer families and communities.

Table of Contents

List of Tables

List of Figures

Chapter 1

Introduction

Domestic violence (DV) is a serious public health and social concern that can result in homicide (World Health Organization, 2013). In recent years, domestic violence death review committees (DVDRCs) have illuminated the important role professionals have in intervening and preventing domestic homicides, including child homicides within this context (Hamilton, Jaffe, & Campbell, 2013; Jaffe & Juodis, 2006; Ontario Domestic Violence Death Review Committee, 2018). Many reviews have found that families had involvement with community service providers prior to the homicide and there is increasing pressure for service providers to enhance their screening for high-risk circumstances (Ontario DVDRC, 2018; Websdale, 2010).

One crucial system intervener when children are involved is the child protection system. The child protection system is expected to understand and consider the possibility of child lethality within the context of domestic violence. Despite improvements in child protection standards in recognizing the risk to children exposed to domestic violence, it is acknowledged that child protection workers face barriers. These include a inadequately addressing the dynamic nature of risk that impacts safety planning and risk management in families where risk of domestic homicide is the primary concern (Alaggia, Shlonsky, Gadalla, Jenney, & Daciuk, 2015; Stanley, Miller Richardson Foster & Thomson, 2011).

My doctoral research seeks to explore the barriers and facilitators for the assessment of risk and safety in high-risk domestic violence cases within the Ontario child protection sector. The research applied the exposure reduction and retaliation, or backlash hypothesis (Dugan et al., 1999, 2003), and the ecological framework (Heise, 1998) to help frame the emerging questions in the field regarding intervention in high-risk domestic violence cases in the child protection

sector. The goal of the research was to shed light on the important factors that facilitate adequate risk assessment practices that inform risk management and safety planning efforts, and to identify and support the implementation of promising practices in cases of domestic violence within the child protection sector. Findings from this research have practical implications for child protection workers who assess risk and child safety in the context of domestic violence situations.

1.1 Research Questions

The overarching research questions guiding this dissertation are, "What are the barriers Ontario child protection workers face in assessing risk from domestic violence reports, and what do they need to overcome these barriers? What does the child protection sector need to intervene effectively in DV cases?" This dissertation is presented in integrated article format. The chapters are written as independent manuscripts and formatted for publication. Chapter two examined domestic homicide cases and prior involvement with child protection services to understand the potential missed opportunities for intervention and lessons to be learned for future prevention. Chapters three and four examined the current state of affairs in child welfare as reported by key informants in the field regarding the assessment of risk in DV cases. The following questions focus the three manuscripts more directly:

1. What is the nature of involvement of the child protection sector prior to the cases of domestic homicide, and how can the sector learn from these tragedies?
2. What does risk assessment in DV cases look like for Ontario child protection workers? Specifically, how often do they use risk assessment strategies and structured tools in their practice?

3. How do child protection workers understand and assess risk in DV cases and what do they think interferes with doing so effectively? Secondly, what are some promising practices that child protection workers use to help overcome these identified barriers?

1.2 Relevant Literature

The next section provides an overview of the current literature in the field. Emerging questions are reviewed by examining the topics of domestic violence and domestic homicide involving adult and child victims, as well as the debates around shortcomings in the traditional response of the child protection system.

Domestic Violence in Canada

DV is a serious health, social, and criminal issue globally (World Health Organization, 2013). Domestic violence (DV) is "the abuse, assault, or systematic control of someone by an intimate partner" (Cunningham & Baker, 2007). DV constitutes a wide range of controlling behaviours, from specific incidents to prolonged patterns of emotional, physical, sexual, and economic abuse (Jaffe, Wolfe, & Campbell, 2012). One-third of Canadian women will experience at least one incident of physical or sexual violence in their lifetime (Sinha, 2013). Although both men and women may use violence in their intimate relationships, research demonstrates that male-perpetrated violence against women often results in more severe consequences, including serious injury or death (Sinha, 2013; Statistics Canada, 2016).

Recognition of the Impact of Exposure to DV on Children

Burgeoning research in the 1990s on the impact of childhood exposure to DV led to reforms in child welfare legislation that recognized it as a form of child maltreatment (Edleson, 2004). The adverse impact of the exposure to DV on children's development is well-documented in the literature (Fantuzzo et al., 1991; Gonzalez et al., 2014; Holt, Buckley, & Whelan, 2008;

Wolfe et al., 2003; Zarling et al., 2013). Childhood exposure to DV is associated with significantly greater behavioural, emotional, and cognitive functioning problems, and children exposed to DV may be at risk for maladjustment that continues into adulthood (Edleson et al., 2007).

Defining Childhood Exposure to Domestic Violence

The term "exposure to domestic violence" (EDV) encompasses hearing, seeing, or being used in a direct incident of physical or verbal violence (Edleson et al., 2007; Public Health Agency of Canada, 2010). Moreover, it is increasingly recognized that children can be impacted by DV through awareness of the violence between their caregivers, even if they have never directly witnessed any acts of violence (Public Health Agency of Canada, 2010; Wathen & MacMillan, 2013). Children may also be impacted through exposure to emotional violence between intimate partners (Public Health Agency of Canada, 2010). It is important to outline how child exposure to adult DV is conceptualized and consequently assessed.

Prevalence of childhood EDV in Canada. Although it is difficult to estimate the prevalence and incidence of childhood EDV, the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), and the provincial/territorial versions, is recognized as the most comprehensive and reliable reporting of child maltreatment investigations by child protection services (Public Health Agency of Canada, 2010). Nationally, the CIS found that 34% of the substantiated investigations of child maltreatment in 2008 were specific to EDV (Public Health Agency of Canada, 2010).

Findings from the 2013 OIS report indicate that exposure to intimate partner violence represents the largest proportion of substantiated maltreatment investigations – almost half (48%) of all substantiated investigations fall under this category as the primary form of

maltreatment (Fallon et al., 2015). Furthermore, findings from an American study examining the prevalence of children's direct exposure to types of DV crime from a large database of 1,560 police substantiated DV events found that children were present in almost half of all DV events, and over 80% of these children were directly exposed to the violence (Fantuzzo & Fusco, 2007). Estimates indicate that over half of victims of DV in Canada have children who witnessed incidents of violence (Kaukinen, Powers & Meyer, 2016). Moreover, there is a high rate of co-occurrence between rates of domestic violence exposure and other forms of child maltreatment, with rates of 60 to 75 percent commonly cited (Wathen & MacMillan, 2013).

Domestic Homicide

The intimate partner homicide rate in Canada from 2003-2013 ranged from 6 to 8 per million spouses, with the highest rates being among 20 to 44-year olds (Statistics Canada, 2015). There is substantial evidence that men perpetrate most domestic homicide (Websdale, 1999; Ontario DVDRC, 2018). Most intimate partner homicides exhibit common patterns and antecedents, and are more likely to be planned killings rather than random or spontaneous acts of rage (Websdale, 2003). Researchers have come to understand that there are a number of interrelated risk factors which increase the likelihood that a violent relationship will become lethal. With this knowledge, a woman's current level of risk can be identified, and appropriate case-specific safety planning can be implemented (Hardesty & Campbell, 2004).

Children's exposure to domestic homicide. The impact of domestic homicide on families cannot be overstated. Children may lose one or both parents (resulting from homicide victimization, suicide, or incarceration) or have to deal with the trauma and aftermath associated with exposure to the violent incident (Alisic et al., 2017; Jaffe, Campbell, Hamilton, & Juodis, 2012; Jaffe, Campbell, Reif, Fairbairn, & David, 2017). A child's exposure to domestic homicide

can have profound effects on their development and later life course as they navigate through their own relationships (Richards, Letchford, & Stratton, 2008). In rare cases, children may be harmed or killed as a result of DV, either being caught in the crossfire or as an act of revenge against the primary victim.

Children at risk of domestic homicide. In some cases, children are killed within the context of domestic homicide. A comprehensive review of child homicides in Canada found that 1,612 children had been killed by their parents between 1961 and 2011 (Dawson, 2015). A recent review of 418 Canadian domestic homicide cases between 2010 and 2015 found that 37 children were killed in this context (Dawson et al., 2018). In a qualitative review of 15 annual Domestic Violence Death Review Committee (DVDRC) reports from the United States and Canada, Jaffe and Juodis (2006) identified three scenarios in which children were killed: indirectly as a result of attempting to protect a parent during a violent episode; directly as revenge against the partner who decided to end the relationship or for some other perceived betrayal; or directly/indirectly as part of an overall murder-suicide plan by a parent who decides to kill the entire family. Websdale (1999) identified three major situational antecedents present in domestic child homicides: history of child abuse, history of domestic violence, and prior contact with various agencies. Other related factors included poverty, inequality and unemployment; criminal history of the perpetrator; substance use/abuse and access to weaponry (Websdale, 1999).

Similarly, Campbell (2004) reported that perpetrators of homicide and attempted homicide were three times more likely to have been reported for child abuse than the batterers in the comparison group of abusive men. By understanding child maltreatment and domestic violence as potentially occurring together, adequate safety planning can be made for the child to reduce their risk of harm. Much of the knowledge on risk and safety in DV cases has emerged

from domestic violence death reviews. These review teams have been at the centre of efforts to prevent future tragedies by gathering information and providing policy and practice recommendations to the public.

Domestic violence death reviews. In recognizing the profound impact of domestic homicides on individuals, families, and communities, along with the acknowledgement that a history of DV often precedes a domestic homicide, domestic violence death review committees were established to inform and strengthen prevention efforts (Bugeja, Dawson, McIntyre & Walsh, 2015; Dawson, 2017). Consisting of experts from a variety of sectors, these committees examine systemic and individual factors that occur within the context of domestic homicide through retrospectively analyzing individual domestic homicide case files. Detailed descriptive and demographic information is gathered to determine risk factors, missed opportunities for intervention, system contacts before the homicide, opportunities for policy reform, and gaps in system collaboration and service delivery (Bugeja et al., 2015). These reviews seek to illuminate issues in service coordination, education/awareness and training, identify risk factors to help predict potential lethality, and reduce missed opportunities for intervention and prevention (Dawson, 2017).

While the interdisciplinary and prevention-focused model of death review committees is supported in the literature, the effectiveness of the committees is difficult to determine due to the challenge in establishing a causal relationship between such committees, their recommendations, and the incidence of deaths (Bugeja et al., 2015). However, death review teams are only one component of a wider set of reforms that may be required to prevent DV. Such reforms are crucial in raising awareness and shifting societal beliefs about DV. Domestic violence death review committees have been developed in the United States, Australia, New Zealand, the

United Kingdom, and Canada (Dawson, 2017). In Canada, several provinces have established Domestic Violence Death Review Committees including Alberta, British Columbia, Manitoba, New Brunswick, Ontario, and Saskatchewan (Canadian Domestic Homicide Prevention Initiative, 2017).

Risk factors for child lethality in the context of DV. The assessment of lethal risk posed to children living in homes with DV is an area that requires careful consideration. At the centre of this issue is identifying risk factors that are unique to child homicide. Research has identified several common interrelated risk factors that increase the likelihood of an intimate partner relationship becoming lethal, most significantly a history of DV and actual or pending separation (Kropp, 2008; Ontario DVDRC, 2018). However, what remains unclear is the risk factors that specifically place a child at risk for lethality (Jaffe, Campbell, Hamilton & Juodis, 2012; Humphreys & Bradbury Jones, 2015). Acknowledged within the literature is the complex nature of assessing risk with families experiencing DV (Fleck-Henderson, 2000; Hughes & Chau, 2013; Radford et al., 2006; Shlonsky & Friend, 2007).

Reviews of domestic homicides indicate that fathers comprise 57% of Canadian filicide perpetrators (Dawson, 2015). Further, fathers appear more likely to kill children as an act of revenge following an actual or pending separation along with a history of DV (Dawson, 2015; Ewing, 1997; Lawrence, 2004). In the literature on safeguarding children living with DV, parental separation is well-documented to be a time of increased risk for lethality and severe violence (Bragg, 2003; Humphreys & Bradbury Jones, 2015; Kirkwood, 2013; Lessard et al., 2010; Wendt, Buchanan & Moulding, 2015). A few similar studies have identified mental health issues (e.g., depression, psychosis) in perpetrators to be present often prior to the homicide (Jackson, 2012; Sillito & Salari, 2011; West, 2009). One study that examined data collected from

domestic homicide case reviews in Ontario found no unique factors that differentiated cases where children were killed from cases where children were not killed, aside from the fact that there were significantly more community service agencies involved with the family prior to the homicide in cases where children were killed (Hamilton, Jaffe & Campbell, 2013). This finding highlights the important role that service providers have in domestic homicide prevention.

DV and the Child Protection Sector

One of the most critical systems in addressing the needs of children exposed to DV is child protection services (CPS). In Ontario, the role of CPS in EDV cases is to investigate reports and provide protective and preventive services when appropriate. The execution of this role may vary widely across jurisdictions.

In Ontario, the *Child, Youth and Family Services Act* outlines what constitutes child abuse and neglect. There is no specific clause in the *CYFSA* that explicitly identifies exposure to DV as a reason to find a child in need of protection (CYFSA, 2017). However, child protection concerns related to DV can be addressed through the clauses 'physical harm or risk of physical harm' (74.2.b) and 'emotional harm or risk of emotional harm' (74.2.f1; CYFSA, 2017). While the legislation does not specify DV as a reason to find a child in need of protection, child protection provincial standards does outline DV as a risk. The progression to recognizing DV as a child protection concern began with amendments to the Ontario child protection standards in 2000, outlined in the *Ontario Risk Assessment Model*, which specified the need to assess the risk to the child based on family violence exposure. Then, the 2007 adoption of the *Differential Response Model* set out a requirement to screen all referrals for DV, but suggested in practice notes that not all exposure to DV should be deemed as emotionally harmful. In 2017, the child protection legislation was amended to raise the age of a child in need protection to 18 years of

age. Additionally, a recent amendment to the *Ontario Child Welfare Eligibility Spectrum* (2016) has included an item titled "risk of dangerousness and lethality in the context of partner violence." The inclusion of this item is based on a recommendation from the Ontario Domestic Violence Death Review Committee. The item identifies several risk factors for the child protection worker to assess lethal risk.

Children's Aid Societies in Ontario have the exclusive mandate by the *CYFSA* to protect children and youth who have been, or are at risk of being, abused and/or neglected by their caregivers, to provide for their care and supervision where necessary, and to place children for adoption (CYFSA, 2017). There are currently a total of 50 Children's Aid Societies in Ontario that are funded by the Ministry of Child, Community and Social Services (Ontario Association of Children's Aid Societies, 2019; Wegner-Lohin, Kyte & Trocme, 2014). Following a report of suspected child abuse or neglect by a professional or community member to the local Children's Aid Society, each report is assessed and responded to by a child protection worker (CPW) based on the *Child Protection Standards* and the O*ntario Child Welfare Eligibility Spectrum.* The *Eligibility Spectrum* is an instrument designed to assist child protection staff in making consistent and accurate decisions about a child or family's eligibility for service at the time an agency becomes involved. The *Child Protection Standards* ensure CPWs provincially follow consistent intervention practices.

The CPW discerns if there are "reasonable and probable grounds that a child may be in need of protection," and if so, an investigation occurs (Wegner-Lohin et al., 2014). The *Differential Response Model* allows for an investigation to be completed using either: (1) a "traditional approach" (focused on ascertaining facts and collecting evidence in a legally defensible manner); or (2) a "customized approach" (utilizes a more flexible, individualized

approach in less severe cases; Wegner-Lohin et al., 2014). If it is deemed that abuse has been substantiated, and as a result a child is in need of protection, child protection workers will open the case for ongoing services. A recent amendment to the Eligibility Spectrum (2016) has included an item titled 'risk of dangerousness and lethality in the context of partner violence'. The inclusion of this item is based on a recommendation from the Ontario DVDRC and identifies several risk factors for the child protection worker to assess lethal risk. Identifying the reason for service as 'risk of dangerousness and lethality' is a system red flag for high-risk DV cases.

Assessing for Risk of Lethality in EDV Cases in the Child Protection Sector

There is extensive research on child protection practice and interventions with families where DV is a primary concern (Hughes & Chau, 2013; Hulbert, 2008; Lapierre & Côté, 2011; Lavergne et al., 2011; Mills et al., 2000; Pennell, Rikard & Sanders-Rice, 2014; Postmus & Merritt, 2010; Shlonsky & Friend, 2007). Overall, there is a concern that child protection workers may not always accurately identify the presence of DV (Bourassa Lavergne, Damant, Lessard, & Turcotte, 2006; Kohl, Barth, Hazen, & Landsverk, 2005; Rivers, Maze, Hannah & Lederman, 2007).

The child protection sector has been criticized for lacking guidance on both the methods and timing of child welfare interventions in cases of EDV (Edleson, Gassman-Pines, & Hill, 2006). There are concerns that CPS holds mothers solely responsible for ending the violence (Douglas & Walsh, 2010; Alaggia, et al., 2015; Humphreys & Absler, 2011). Various factors may exist as obstacles to child protection workers effectively detecting DV in families, including: parents' denial, lack of evidence, heavy workloads of workers, lack of cooperation by parents, short duration of interventions, and parental substance abuse (Bourassa et al., 2006;

Kohl et al., 2005). Irrespective of these problems, risk assessment is an important starting point that can be guided by using structured tools.

Standardized assessment tools used in child protection. Research conducted within child protection systems has demonstrated that a significant number of children under protective supervision are exposed to DV, however screening and investigation of the violence is often insufficient (Hazen, Connelly, Kelleher, Landsverk & Barth, 2004). Alarmingly, in Ontario, there are no standardized tools within child protection services that specifically assess for the risk of child lethality in the context of DV (Ontario Ministry of Children and Youth Services, 2016).

The Ontario Ministry of Children and Youth Services outlines risk assessment tools as per the Ontario Child Protection Standards. The tools include: Safety Assessment, Family Risk Assessment, Family and Child Strengths and Needs Assessment, Family Risk Reassessment, Reunification Assessment Tools (Ontario Ministry of Children and Youth Services, 2016). These assessment tools utilized in child protection are not specific to lethality risks posed by DV (Jenney, 2011; Shlonsky & Friend, 2007). DV may be one factor that child protection workers consider as part of their standards of practice for assessment, but DV as a single risk factor does not influence their decision making (Hughes & Chau, 2013). While child protection workers may base their assessments and interventions on factors typically included in risk assessment tools, their process for assessing risk to children involves engaging in a complex decision-making process with attention to how the violence impacted the children, along with the caregivers' willingness to accept responsibility and make changes (Hughes & Chau, 2013).

In their review of the literature on the utility of risk assessment tools in the context of child maltreatment and DV, Shlonsky and Friend (2007) articulate that good risk assessment

instruments are better at predicting future child maltreatment than clinical judgment alone. The CPW plays a crucial role in assessing the dynamic context of child maltreatment and DV. Standardized risk assessment tools for DV have not been normed on populations involved with child protection, which has impacts on the validity and reliability of their usage within this sector.

Furthermore, the role within child protection of assessing risk in families where there is DV has been unclear (Jenney, 2011; Kohl et al., 2005; Postmus & Merritt, 2010; Radford et al., 2006; Shlonsky & Friend, 2007). Personal (e.g., demographic characteristics) and professional (e.g., prior case experience, agency policies and protocols) factors can influence a child protection worker's beliefs about DV and subsequently their response (Postmus & Merritt, 2010). One study of various social service workers found that while child protection workers had more knowledge of DV than other workers, child protection workers had insufficient knowledge about communicating the risks for lethality and effective interventions with perpetrators (Button & Payne, 2009). Moreover, depending on how the level of risk to the child is conceptualized (i.e., directly or indirectly harmed, physically or emotionally), child protection workers may not remain involved with the family and miss the opportunity to address ongoing dynamic risk factors (Hughes & Chau, 2013).

Best practices for assessing risk of lethality within child protection have not been well-documented in the literature and may in fact not be well-developed and vary amongst communities. Additionally, it has been argued that in EDV cases, the field of child protection has been slow to recognize that developing collaborative best practices for establishing safety with the mother is synonymous with ensuring safety for the children. (Hughes, Chau, & Poff, 2011; Shlonsky & Friend, 2007). Often, child protection investigations involving DV result in

directives for the mother to separate from the abusive partner. On one hand, this intervention is intended to keep the perpetrating partner from exposing the children to further violence in the home. On the other hand, it could result in the mother feeling coerced to separate when she is not ready, or leave her to deal with the consequences of the perpetrating parent continuing the coercive control through protracted legal disputes. Some research suggests that the child protection system is reluctant to get, or stay, involved in cases where the separated parents are subsequently involved in a family court dispute for fear of being drawn into the dispute by conflicting allegations (Lessard et al., 2010).

Finally, with respect to the role of risk assessment with perpetrating fathers, although there is a push for CPS practice to focus on the assessment and intervention of the perpetrator's abusive behavior, a barrier in achieving this is the conflicting perspectives on how to best provide services to perpetrators (Healy & Bell, 2005; Lessard et al., 2010).

Child Protection Role in Managing Risk

While there is a recommendation that child protection practice focus on the perpetrator's behaviour and implement interventions aimed at addressing DV, one barrier in achieving this is the conflicting perspectives on how to best provide services to perpetrators (Healy & Bell, 2005; Lessard et al., 2010). The priority and mandate for child protection services are geared towards protecting children (and by extension, mothers), thus workers may find it difficult to engage effectively with perpetrating fathers (Jenney, 2011). An Ontario study examining the child protection service outcomes of the differential response model in DV cases found that only about one-third of perpetrating partners were successfully contacted or investigated in DV cases (Alaggia et al., 2015).

In order to facilitate child protection procedures that address DV perpetrators behaviours, there is a need to increase child protection workers' knowledge about how best to address these behaviours (Healy & Bell, 2005). CPWs require the skills and willingness to engage perpetrators in a change process that ensures the child and mother's safety (Jenney, 2011). Previous research on CPWs own perspectives of their services has identified a lack of training being provided that specifically examines how to manage DV perpetrators behaviours (Jenney, 2011; Stanley et al., 2012). Child protection workers have expressed difficulties working with perpetrators of DV and comment on the limited resources at their disposal when working with perpetrators (Lapierre & Côté, 2011). Furthermore, the lack of information being shared between organizations, as well as power imbalances, has often created difficulty for the effective coordination of services (Lessard et al., 2010). While the child protection sector has made significant improvements in working with victims of DV, there is an overall indication in the literature that CPWs need continued training, supervision and support aimed at increasing skills and confidence in working with perpetrators of DV (Stanley & Humphreys, 2014).

Child Protection and Safety Planning

Risk assessment should lead to safety planning. Safety planning for children exposed to DV is utilized in both the DV and child protection sectors. In many jurisdictions, safety planning within child protection is a structured and mandatory response to a child protection referral (Fleck-Henderson, 2000). Within the DV sector, safety planning is often undertaken with the victim parent following a disclosure of DV. Victim safety planning may be undertaken with victim service providers, either through police services or non-governmental services, including shelters, along with police, probation and parole officers, family services and family justice officials (Department of Justice Canada, 2013). Much of the literature suggests that effective

safety planning includes both the mother and her children, along with cross-disciplinary collaboration that is guided by risk assessment (Kohl et al., 2005; Waugh & Bonner, 2002). Further, there is a need to develop differential plans that respect victim autonomy but place children's safety at the forefront, with severity of violence and degree of coercive control tactics used guiding the safety measures taken (DeVoe & Smith, 2003; Jaffe, Crooks & Bala, 2009).

Within the child protection sector, safety planning for children living with DV requires knowledge of DV dynamics, and mobilizing a plan based on information gathered from assessing the level of risk. Jenney (2011) suggests that child protection workers should consider differentiating DV cases from other forms of child maltreatment to expand the narrow view of what constitutes safety (i.e., leaving the abusive relationship) and incorporate more pragmatic solutions to improving the safety of women and children (i.e., engaging with men to end abusive behaviours). Given the complex nature of DV, it is suggested that professionals seek to find adaptive and dynamic models for intervention that considers previous evidence and current self-report (Jenney, 2011). For example, separation is a dynamic factor that elevates risk and needs to be specifically addressed in a safety plan (Brown & Tyson, 2012; Jaffe et al., 2015). While it is important to create safety plans that are standardized, it is suggested that they remain flexible as each case and family is unique (Horton et al., 2014). Often in the context of DV, the primary focus for professionals is planning for the safety of the mother and her children (Jaffe et al., 2015; Thomas, Goodman & Putnins, 2015). There is a close relationship between the safety of the mother and the welfare and safety of her children (Hughes et al. 2011; Shlonsky & Friend, 2007; Wendt et al., 2015). Keeping children safe in cases where DV is present requires a thorough assessment of nature of the risk factors they face.

1.3 Theoretical Perspectives

There are two theoretical perspectives that inform the epistemological basis of this study. The exposure reduction and subsequent retaliation, or backlash hypothesis (Dugan et al., 1999, 2003), and the ecological model (Heise, 1998). Together, these theories aid in conceptualizing the research and aids in examining why children are more vulnerable to harm when living with DV, as it illuminates the societal/structural nature of the issue. The following section will outline each theoretical perspective.

Exposure Reduction and Subsequent Retaliation/Backlash Hypothesis

Intimate partner homicide rates in Canada have declined over the past 30 years (Statistics Canada, 2016). There is growing awareness that an exposure reduction theoretical framework can explain this decline (Dawson et al., 2009; Dugan et al., 1999, 2003). This framework hypothesizes that increases in methods that support intimate partner victims leaving abusive relationships, or that deter the development of violent relationships in the first place, reduces DV (Dawson et al, 2009). The increased accessibility of DV prevention resources, and lethality risk assessment tools that aid in safety planning, are two such methods (Dawson, 2001; Dugan et al., 1999, 2003).

However, there is also evidence to suggest that, in certain circumstances such as when children are involved, exposure reducing mechanisms may increase the likelihood of a domestic homicide through a backlash or retaliation effect (Dugan et al., 2003; Reckdenwald, 2008). In these cases, it may arise when the mechanism or intervention in fact “angers or threatens the abusive partner without effectively reducing contact with the victim” (Dugan et al., 2003, p. 174). This may be further exacerbated when children are involved due to the added pressure for contact with the perpetrator as they are presumed to be safe fathers until the risk they pose is determined in criminal or family court (Dugan et al., 2003).

Research on domestic homicides in the United States has demonstrated that although the overall homicide rate has declined in the past 50 years since the inception of DV services for women, a closer examination of these rates reveals that it is only female-perpetrated domestic homicide that has declined (Reckdenwald & Parker, 2010). Separation is a dangerous period, particularly in severely violent relationships, and researchers have established that increased attention to victim safety, as well as risk management of the perpetrator, is critical (Dawson, 2010; Dugan et al., 2003).

In the child protection system, the response to DV is largely grounded in the underlying rationale/assumption that couples must separate due to harmful effects on children of being exposed to DV (Edleson et al., 2007). While this logic is not inherently flawed, it does not fully consider the complicated dynamics of coercive control, and that separation is a time of heightened risk for lethality for the victim and her children (Brown & Tyson, 2012). In part, structural aspects of this system often result in child protection worker's placing the responsibility of keeping the children safe solely on the shoulders of the mother (Shlonsky & Friend, 2007). This can lead to the edict that they must separate or face losing the children. Without adequate risk management for the perpetrator or safety planning for the victim and her children during this time, the lives of women and children are at stake.

The broader system response, including the child protection, police, legal system (criminal, family, and child protection) sectors, can be fragmented and compartmentalized when key professionals in these systems do not coordinate services and collaborate with the victim parent to manage risk and plan for the safety of all involved. The retaliation hypothesis comes into effect when these systems operate in a siloed fashion, not effectively working together to plan for the safety of the victim and her children, and not managing the risk of the perpetrator

(Hester, 2011). Although the increased availability of resources is beneficial, there is a risk for retaliation in relationships that have more severe forms of violence when inadequate interventions or ineffective strategies are provided. The reduction of risk is hard to achieve when children are involved because the assumption is made for ongoing contact with the perpetrator. Unless service providers recognize risk and/or family court makes the finding of DV and endorses risk reduction, children remain in harm's way.

Ecological Framework

The Ecological Framework allows for an exploration of the etiology of DV and subsequent appropriate prevention and intervention efforts. Initially conceptualized by Bronfenbrenner (1979), this model is based in a contextual understanding of an individual, that is an individual is understood in the context of their environment. Examining the issue through an ecological framework, DV is understood to be caused by a complex combination of compounding and contributing factors at the individual, family, community, and societal level (Heise, 1998). There is an interplay among individual, interpersonal, community, organizational, and broader policy factors that must be considered in order to understand the various risks and protective factors for experiencing or perpetrating DV. An ecological framework looks at the causality of DV through superimposed layers, whereby predictive, pre-disposing, and perpetuating factors of violence are examined at each level, as well as in their interaction across levels (Daro, Edleson & Pinderhughes, 2004; Heise, 1998).

Interventional efforts can be targeted at various levels of the ecological framework (Heise, 1998). At the individual and interpersonal levels, prevention strategies can be focused on shifting attitudes and behaviours, through promotion of healthy relationships, and conflict resolution (Centers for Disease Control and Prevention, 2015). Prevention and intervention

strategies at the community, organizational, and policy levels can be directed at the systems with which the victims, perpetrators, and children may be involved. Across these three levels, violence prevention strategies can be incorporated through improving public policy on inhibiting the acceptance of violence and improving the response (Danis, 2003). Violence prevention service delivery must be sustainable and commitment to social change needs to be incorporated by professionals (Ungar, 2002).

Moreover, interactions between all levels, such as coordinated community approaches, can heighten a community's ability to enhance its' assets and maximize opportunities to reduce DV (Obasaju, Palin, Jacobs, Anderson & Kaslow, 2009). Challenges can be treated through various system levels and treatment can be thought of as a strategy that improves the transactions between individuals and their environments (Obasaju et al., 2009). The ecological framework is a unifying lens to understand responses to DV as it focuses on the intersection of diverse problems and allows for the lessons learned in one domain to be applied to problems identified in another (Daro et al., 2004).

1.4 Situating the Current Research

Changes to child protection legislation that include EDV as a form of child maltreatment has resulted in increased referrals. As tracked on a provincial level, the number of EDV investigations increased fivefold between 1998 and 2013 (Fallon et al., 2015). This change presented a challenge to CPS in terms of their response to this volume of cases. Coinciding with these reforms has been the implementation of child protection standards that emphasize risk reduction and the use of standardized risk assessments as part of their model of practice (Alaggia, Jenney, Mazzzuca & Redmond, 2007). In Ontario however, the risk assessment tools

utilized in child protection agencies as outlined by the Ministry of Children, Community and Social Services are not specific to the risk of lethality in cases of DV.

Given the high incidence rates of EDV in child welfare populations, the practice of assessing risk to children is a necessary component in child protection work. The assessment of risk in cases of DV is crucial to adequately inform safety planning efforts. While legislation identifies exposure to partner violence as a form of child maltreatment under emotional harm, there are limited directives to implement clear policies and protocols for intervening and assessing risk specific to DV (Jenney, Mishna, Alaggia, & Scott, 2014; Nixon, Tutty, Weaver-Dunlop & Walsh, 2007). As such, the nature of risk assessment and management varies considerably across jurisdictions and organizations. Child protection services are in a unique position within the DV service sector, to engage, or even mandate, parents who perpetrate DV into specific risk reduction programs, yet it is more likely that the victim parent will be the focus of services (Alaggia, Jenney, Mazzuca & Redmond, 2007; Douglas & Walsh, 2010; Mandel, 2010; Shlonsky & Friend, 2007).

While amendments to the Ontario child protection legislation and Ministry standards/ service policies have led to an increased focus on the risks to children exposed to DV, research with service providers has demonstrated there are continued service challenges related to the reluctance of victims to disclose or seek services, compartmentalized operation of DV service sectors, increased demand for services, higher frequency of surveillance of mothers, and decreased accountability of perpetrators (Alaggia et al., 2007). Given the challenges cited in the literature, I wanted to explore the role that CPS can play in preventing domestic homicides through a series of three connected studies.

1.5 Overview of Individual Studies

Study one. The first study examined prior child protection services involvement in 107 domestic homicide cases reviewed by a domestic violence death review committee in Ontario, Canada. Recommendations made by the committee to the child protection sector were also reviewed through thematic analysis. This retrospective case analysis included cases reviewed by the committee from 2003 to 2016. The database is maintained at Western University and we received approval from the Office of the Chief Coroner as well as the Western University's non-medical research board to access this database.

The second and third papers utilized a subset of data from the second phase of the *Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations* (CDHPIVP), which is a multi-year, multi-site Social Sciences and Humanities Research Council grant of which my doctoral advisor is a co-director. The CDHPIVP is a national initiative to help inform promising practices in domestic homicide prevention through exploring the unique needs of Indigenous, immigrant and refugee, rural, remote, and northern communities and children exposed to domestic violence. The project involved 14 co-investigators across ten universities and approximately 50 partner organizations. For the purpose of the project, the research team developed definitions of risk assessment, risk management, and safety planning (see Appendix). I had the opportunity to be involved with the CDHPIVP as a graduate student research assistant.

Study two. The second paper aimed to obtain a snapshot of risk assessment practices and safety planning strategies when working with DV cases in the child protection sector in Ontario. Through an online survey, participants were recruited through the partners and collaborators of the CDHPIVP. The survey was hosted by Qualtrics and was available in both official languages from January to May 2017. A total of 138 child protection workers from Ontario completed the survey.

Study three. The third and final paper focuses on the perspectives of 29 child protection workers in Ontario who were interviewed on their risk assessment, risk management, and safety planning practices in the context of domestic violence. These participants were recruited through the survey from my second study. Interviews were conducted over the phone between June 2017 and August 2018 by senior graduate research assistants involved with CDHPIVP. Interviews were audio-recorded, transcribed verbatim, and analyzed through a web application for qualitative research.

1.6 Summary

Taken together, the articles presented in this dissertation were designed to add to the literature on addressing the complexities of working in the intersection of child welfare and domestic violence. The exposure reduction/retaliation hypothesis as well as the ecological framework provide contexts to understand the issue as a multi-level problem involving responses at the individual, organizational, and systemic level; the results of this dissertation are interpreted through these models.

The results of this dissertation revealed several areas in which child protection workers face challenges in working with DV cases and how the system can respond to better meet the safety needs of families. Together, the perspectives of child protection workers who are involved with these cases, along with the lessons learned from the tragedies of extreme violence, provide a depiction of how workers integrate the knowledge gleaned from research into their practice to keep families safe.

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Chapter 2

Examining the Role of Child Protection Services in Domestic Violence Cases: Lessons Learned from Tragedies

Abstract: Exposure to domestic violence (DV) reports account for a significant portion of child welfare cases. However, there is a lack of resources for specifically working with cases that present a high-risk for lethality. The present study examined the involvement of child protection services (CPS) prior to domestic homicide cases reviewed by a domestic violence death review committee in Ontario, Canada. The study also examined the recommendations made by the committee to the child welfare sector. Overall, less than one-quarter of the homicide cases with children in the family system had CPS involvement. There were no differences in the presence of CPS involvement in cases where children were killed compared to cases where children were not killed. CPS-involved cases had significantly more risk factors and the family was involved with significantly more agencies overall. Recommendations directed to the child welfare sector highlighted the need for enhanced ongoing service provision to promote safety and hold perpetrators accountable, specialized DV training, and increased cross-sector collaboration. The findings stress the importance of multi-disciplinary collaborations, and specialized ongoing training in engaging perpetrators and managing risk.

2.1 Introduction

In recent years, domestic violence death review committees (DVDRCs) have illuminated the important role professionals have in intervening and preventing domestic homicides (Dawson et al, 2017), as well as child homicide within this context (Hamilton et al., 2013; Jaffe & Juodis, 2006). Many of the domestic homicide reviews found that when victims were living with children, the family tended to have involvement with community service providers prior to the homicide (Hamilton, Jaffe & Campbell, 2013; Mills et al., 2000; Ontario DVDRC, 2018; Websdale, 1999). Given the known warning signs, there is increasing pressure for community agencies and the justice system to enhance their screening for high-risk circumstances (Websdale, 2010; Jaffe, Campbell, Reif, Fairbairn & David, 2017). Child protection services play a critical role in assessing risk and ensuring child safety for children living with domestic violence. This study focused on the potential child protection services role in assessing the risk of escalating violence and homicide.

Research in the 1990s on the adverse impact of childhood exposure to DV led to reforms in child welfare legislation that recognized it as a form of child maltreatment (Edleson, 2004; Fantuzzo et al., 1991; Gonzalez et al., 2014; Holt, Buckley, & Whelan, 2008; Wolfe et al., 2003; Zarling et al., 2013). Childhood exposure to DV is associated with significantly greater behavioural, emotional, and cognitive functioning problems, and children exposed to DV may be at risk for maladjustment that continues into adulthood (Edleson et al., 2007). The term exposure to domestic violence (EDV) encompasses a range of conditions including: hearing, seeing, or being used in a direct incident of physical or verbal abuse, or through observing the aftermath of violence, such as injuries to the victim parent, or damage to property (Edleson et al., 2007; Public Health Agency of Canada, 2010; Wathen & MacMillan, 2013). Children may also be

impacted through exposure to emotional abuse and the exertion of coercive control by a perpetrating parent (Public Health Agency of Canada, 2010).

Prevalence of Childhood EDV in Ontario

Changes to the legislation to include EDV as a form of child maltreatment resulted in a significant increase in referrals, mainly under the emotional maltreatment category, to child welfare agencies across Canada (Trocmé, Fallon, MacLaurin, & Neves, 2005). In Ontario, the 2013 Ontario Incidence Study of Reported Child Abuse and Neglect (OIS) found that investigations opened due to reports of exposure to intimate partner violence were the most substantiated maltreatment investigations conducted by child protection. Almost half (48%) of all substantiated investigations fell under this category as the primary form of maltreatment (Fallon et al., 2015). Furthermore, findings from an American study of a large database of 1,560 police substantiated DV events found that children were present in almost half of all DV events, and over 80% of these children were directly exposed to the violence (Fantuzzo & Fusco, 2007). Child protection workers are faced with the task of assessing child risk in the context of DV and intervening to protect children when necessary. In some cases, DV can be lethal.

Domestic Homicide

The intimate partner homicide rate in Canada from 2003-2013 ranged from 6 to 8 per million spouses, with the highest rates being among 20 to 44-year-olds (Statistics Canada, 2015). There is substantial evidence that men perpetrate most domestic homicides (Caman, Howner, Kristiansson, & Sturup, 2016; Ontario DVDRC, 2018). Most intimate partner homicides exhibit common patterns and antecedents and are more likely to be planned killings rather than random or spontaneous acts of rage (Websdale, 2003). Researchers have come to understand that there are a number of interrelated risk factors which increase the likelihood that a violent relationship

will become lethal, most significantly, a history of domestic violence and actual or pending separation (Kropp, 2008; Ontario DVDRC, 2018). With this knowledge, a woman's current level of risk can be identified by service providers, and appropriate case-specific safety planning can be implemented by them (Hardesty & Campbell, 2004).

Children and domestic homicide. In some cases, children are killed within the context of domestic homicide. A comprehensive review of child homicides in Canada found that 1,612 children had been killed by their parents between 1961 and 2011 (Dawson, 2015). In a qualitative review of 15 annual Domestic Violence Death Review Committee (DVDRC) reports from the United States and Canada, Jaffe and Juodis (2006) identified three scenarios in which children were killed: indirectly as a result of attempting to protect a parent during a violent episode; directly as revenge against the partner who decided to end the relationship, or for some other perceived betrayal; or directly/indirectly as part of an overall murder-suicide plan by a parent who decides to kill the entire family. Websdale (1999) identified three major situational antecedents present in domestic child homicides: history of child abuse, history of domestic violence, and prior contact with various agencies. Other related themes included poverty, inequality and unemployment; criminal history of the perpetrator; substance use/abuse and access to weaponry (Websdale, 1999).

Similarly, Campbell (2004) reported that perpetrators of homicide and attempted homicide were three times more likely to have been reported for child abuse than the batterers in the comparison group of abusive men. By understanding child maltreatment and domestic violence as potentially occurring together, adequate safety planning can reduce the risk of harm to children. Much of the knowledge on risk and safety in DV cases has been gathered from domestic violence death reviews. These review teams have been at the centre of efforts to

prevent future tragedies by gathering information and providing policy and practice recommendations to the public.

Domestic violence death reviews. In recognizing the profound impact of domestic homicides on individuals, families, and communities, along with the acknowledgement that a history of DV often precedes a domestic homicide, domestic violence death review committees were established to inform and strengthen prevention efforts (Bugeja, Dawson, McIntyre & Walsh, 2015; Dawson, 2017). Consisting of experts from a variety of sectors, these committees examine systemic and individual factors that occur within the context of domestic homicide through retrospectively analyzing individual domestic homicide case files. These reviews seek to illuminate issues in: service coordination, education/awareness, and training; to identify risk factors to help predict potential lethality; and to reduce missed opportunities for intervention and prevention (Dawson, 2017).

Risk factors for child lethality in the context of DV. The assessment of lethal risk posed to children living in homes with DV is an area that requires careful consideration. At the centre of this issue is identifying risk factors that are unique to child homicide. Lethality risk factors for primary victims have been established; however, what remains unclear is the risk factors that specifically place a child at risk for lethality in the context of DV (Jaffe, Campbell, Hamilton & Juodis, 2012; Humphreys & Bradbury Jones, 2015). Acknowledged within the literature is the complex nature of assessing risk with families experiencing DV (Fleck-Henderson, 2000; Hughes & Chau, 2013; Radford et al., 2006; Shlonsky & Friend, 2007). Reviews of domestic homicides indicate that fathers comprise 57% of Canadian filicide perpetrators (Dawson, 2015). Further, fathers appeared more likely to kill children as an act of revenge when there was an actual or pending separation along with a history of domestic

violence (Dawson, 2015; Ewing, 1997; Lawrence, 2004). In the literature on safeguarding children living with DV, parental separation is a well-documented time of increased risk for lethality and severe violence (Bragg, 2003; Humphreys & Bradbury Jones, 2015; Kirkwood, 2013; Lessard et al., 2010; Wendt, Buchanan & Moulding, 2015). A few similar studies have identified the presence of mental health issues (e.g., depression, psychosis) in perpetrators prior to the homicide (Jackson, 2012; Sillito & Salari, 2011; West, 2009). The single unique factor present in cases where children were killed compared to not killed, was the involvement of community service agencies with the family prior to the homicide of the child (Hamilton, Jaffe & Campbell, 2013). Outside of these studies, there remains a relative dearth of research examining the unique risks of children being killed in the context of DV (Hamilton et al., 2013; Olszowy, Jaffe, Campbell, & Hamilton, 2013).

Intersection between CPS Intervention and DV

Previous literature has suggested that parents who commit severe or fatal abuse are often known to CPS prior to the incident in question (Costin, Karger, & Stoesz, 1996), and have higher-than-average rates of substance abuse (Famularo, Kinscherff, & Fenton, 1992) and domestic violence (Mills et al., 2000). Although CPS are in a unique position to engage, or even mandate perpetrating parents of domestic violence into specific risk reduction programs, criticism of the system suggests it is more likely that the victim parent will be the focus of services (Alaggia, Jenney, Mazzuca & Redmond, 2007; Douglas & Walsh, 2010; Mandel, 2010; Shlonsky & Friend, 2007). While legislation was formulated on research, and designed to be in the best interest of the child, research with service providers has demonstrated there are barriers to the implementation of these policies, including the reluctance of victims to disclose or seek

services, sectors operating in silos, increased demand for services, higher frequency of surveillance of mother, and decreased accountability of perpetrators (Alaggia et al., 2007).

Theoretical Framework to Examine Child Protection and High-Risk DV Cases

The exposure reduction and subsequent retaliation, or backlash hypothesis (Dugan et al., 1999, 2003), aids in examining why children are more vulnerable to harm when living with domestic violence as it illuminates the societal/structural nature of the issue.

Intimate partner homicide rates in Canada have declined over the past 30 years (Statistics Canada, 2016). There is growing awareness that an exposure reduction theoretical framework can explain this decline (Dawson et al., 2009; Dugan et al., 1999, 2003; Reckdenwald, 2008). This framework hypothesizes that increases in methods that support intimate partner victims leaving abusive relationships or deters the development of violent relationships in the first place, reduces DV (Dawson et al, 2009). The increased accessibility of DV prevention resources and lethality risk assessment tools that aid in safety planning are two such methods (Dawson, 2001; Dugan et al., 1999, 2003).

However, there is also evidence to suggest that, in certain circumstances such as when children are involved, exposure reducing mechanisms may increase the likelihood of a domestic homicide through a backlash or retaliation effect (Dugan et al., 2003; Reckdenwald, 2008). In these cases, it may arise when the mechanism or intervention in fact “angers or threatens the abusive partner without effectively reducing contact with the victim” (Dugan et al., 2003, p. 174). This may be further exacerbated when children are involved due to the added pressure for contact with the perpetrator, as they are presumed safe until the risk they pose is determined in criminal or family court (Dugan et al., 2003).

In the child protection system, the dominant response to DV is largely grounded in the underlying rationale/assumption that couples must separate due to the harmful effects of children being exposed to DV (Edleson et al., 2007). While this may seem like a logical solution to high risk situations, it does not fully consider the complicated dynamics of coercive control, and that separation is a time of heightened risk for lethality for the victim and her children (Brown & Tyson, 2012). In part, structural aspects of this system often result in the child protection worker placing the responsibility for keeping the children safe solely on the shoulders of the mother (Shlonsky & Friend, 2007). This flawed expectation can lead to demand that she separate from the abusive partner or face losing the children. Without adequate risk management for the perpetrator, or safety planning for the victim and her children, the lives of women and children are at stake.

The broader system response, including the child protection, police, legal system (criminal, family, and child protection) sectors, can be fragmented and compartmentalized. The retaliation hypothesis comes into effect when these systems operate in isolation and do not effectively collaborate to plan for safety of the victim and her children, and to manage the risk of the perpetrator (Hester, 2011). The reduction of risk is harder to achieve when children are involved because the assumption is made for ongoing contact with the perpetrator father. Unless service providers recognize the risk and/or family court makes the finding of DV and endorses risk reduction, children remain in harm's way.

The child protection system is expected to understand and consider the harm of exposure to DV on a child's development and the possibility of child lethality in extreme cases. Despite recent improvements in child protection standards and corresponding organizational policies with respect to domestic violence risks, child protection workers experience challenges with

adequately addressing the dynamic nature of risk, which impacts safety planning and risk management in families where risk of domestic homicide is the primary concern (Alaggia, Gadalla, Shlonsky, Jenney, & Daciuk, 2015; Mills et al., 2000; Stanley & Humphreys, 2014). Furthermore, it is unclear the extent to which knowledge gleaned from DVDRCs has been translated into agency policies and practices when working with high-risk domestic violence cases in the child protection sector.

Current Study

Although children are killed in the context of intimate partner violence, they are seldom the focus of research on DV related homicides. Even fewer studies have examined the role of service providers prior to child domestic homicides. Prior research on DVDRC work in Ontario has demonstrated that in cases involving child homicides, there were significantly more agencies involved with the family prior to the homicide (Hamilton et al., 2013). However, there is little research on the nature of child protection involvement prior to a domestic homicide. Given that CPS is mandated to act in the best interests of the safety and well-being of the child, it is important to examine the lessons learned from tragedies.

This study explored the nature of prior contact with child protection services in domestic homicide cases and major areas of recommendations directed to the child welfare sector that have been made by the Ontario DVDRC from 2003 to 2016. The objective of this study was to examine cases where children were killed in the context of DV, and cases where children were present in the family system but not killed, to determine if there were differences in the level of involvement with CPS. The study will examine the following questions:

1. Are there differences in the involvement with CPS in cases where children were killed compared to cases where children were present in the family system but not killed?

2. Of the cases where children were present in the family system, are there differences in the number and types of risk factors, and are other agencies involved in cases that had documented involvement with CPS compared to the cases that did not have CPS involvement?
3. What are the underlying themes of the DVDRC recommendations made to the child welfare sector?

2.2 Method

Data Collection

The current study utilized a retrospective case analysis research design with quantitative data from domestic homicide case summaries obtained from the Domestic Violence Death Review Committee (DVDRC) of Ontario. The DVDRC is a multi-disciplinary advisory committee of domestic violence experts with representatives from law enforcement, criminal justice, the healthcare sector, social services, and other public safety agencies and organizations. Operating out of the Office of the Chief Coroner for the Province of Ontario, the committee conducts case reviews using files obtained from professionals and agencies involved with the perpetrator and victim(s) as well as historical information, and in some cases, police interviews of friends, family members, and co-workers.

Reviews are conducted after all investigations and court proceedings have been completed; some cases are reviewed several years after their occurrence. From these reviews, the committee documents the presence or absence of risk factors based on an established DVDRC coding form (see Appendix). Following a thorough review of a case, the DVDRC makes policy and practice recommendations to provincial governing bodies of various sectors to improve the system response to DV and prevent deaths involving domestic violence from occurring in the

future. Since its inception in 2003, the DVDRC has reviewed 311 cases involving 445 deaths (DVDRC, 2018). At the time of this study, 241 cases were available for analyses in the database.

Materials

I utilized the DVDRC database and individual case reports to examine the nature of CPS involvement in cases where children were present in the family system. The amount of information in each case varied as a result of the discrepancies in prior agency contact and the thoroughness of police investigations.

The dataset came from two pre-existing coding forms and one summary sheet used by the DVDRC to organize data from all cases.

DVDRC risk factor coding form. The first coding form, the DVDRC risk factor coding form, was created by the DVDRC to code information pertaining to each of the DVDRC's 41 risk factors, including whether the risk factor was present (P), absent (A) or unknown (Unk) based on all compiled case reports. Information and definitions pertaining to risk factors are available in the appendix of the DVDRC's 2017 annual report (Ontario DVDRC, 2018). The risk factors included in the form were drawn from the literature as factors related to the risk of lethality in DV contexts. In the database and for this analysis, the risk factors, perpetrator suicide attempts and perpetrator suicide threats, were collapsed into one variable, perpetrator suicide attempts/threats. As well, perpetrator depression in the opinion of professionals and non-professionals were collapsed into perpetrator suicide attempts.

DVDRC data summary form. The second coding form, the DVDRC data summary form, is a 15-page summary based on all case information, including child and service provider information. This form was used to deduce socio-demographic information, service provider involvement, criminal history, case type, and third-party knowledge at the time of the homicide.

Service provider involvement was noted from the agencies/institutions section of the coding form, which asked about the involvement of 34 different service providers including criminal justice, child welfare, and mental health agencies. Third party knowledge was deduced by determining if there were prior reports of domestic violence in the relationship, and if present, who received those reports.

DVDRC summary report. The DVDRC has a summary report of varying lengths for each case that the committee has reviewed. This report provided background information on the case, information about the homicide, and recommendations directed to various governing bodies. The summary report was used to document the recommendations directed to the child welfare sector.

Procedure

Following an oath of confidentiality, the researcher was granted permission by the Chief Coroner and the University of Western Ontario's Ethics Review Board to access and review DVDRC case summaries. Case summary reviews were accessible via electronic files located on a password-protected and encrypted computer. Each case was assigned a study code to ensure confidentiality. Information from DVDRC cases were inputted into a large database and all of the cases are coded to protect the anonymity and confidentiality of all involved parties. Information pertaining to files were kept securely and confidentially on a password-protected and encrypted computer.

All cases were reviewed for the presence of children and classified into one of four groups. The first group, *No Child Target*, indicated that the perpetrator and/or primary victim had biological, step, and/or adopted children under the age of 18, but they were not targeted or attacked. The second group, *Child Target*, indicated there was a child who existed in the family

system, and was the victim of a murder during an incident of domestic homicide or attempted homicide. The third group, *No Child in Family System,* indicated that the perpetrator and/or primary victim did not have biological, step and/or adopted children. Lastly, the fourth group, *Child over 18 or No Contact with Victim or Perpetrator,* indicated that the perpetrator and/or primary victim had children over the age of 18 or they did not have contact with their children at the time of the homicide. Cases were also reviewed for service provider involvement including professionals in the child protection, police, VAW/DV shelter, social services, courts, and healthcare.

Participants

The current study analyzed 191 domestic homicide case summaries obtained from the Domestic Violence Death Review Committee (DVDRC) of Ontario from 2003 to 2016. The 191 cases that were selected fit the following criteria: the primary relationship was heterosexual, each partner was between the ages of 18 to 65, the perpetrator was male, and children 18 years of age or less were present in the family system. Cases with female perpetrators and male victims and same-sex relationships were excluded due to the limited numbers and distinct profiles identified in the literature (Caman, Howner, Kristiansson, & Sturup, 2016). Cases are discussed using the term perpetrator and primary victim. Perpetrator is defined as the person committing the offense. The primary victim identifies the adult female partner in the heterosexual relationship who is the victim of the domestic violence and the primary target of the homicidal violence. See Table 1 for a description of the sample characteristics.

Data Analysis

Chi-square tests of independence were used to compare the child protection involvement on categorical dependent variables. Comparisons were made on case type involving children,

types of risk factors, other service provider contacts and their knowledge of DV within the family, and formal risk assessments. Any cases where a variable being analyzed was unknown were excluded from that analysis. Fisher's exact test was employed for dependent variables where expected counts less than five made up more than 25% of the cells. Independent samples *t*-tests were used to compare the number of risk factors, number of DV-related arrests (victim and perpetrator), and number of service providers as the dependent variables and child protection involvement as the independent variable.

Finally, I reviewed the DVDRC annual reports and the case summary reports to identify and collate the committee's recommendations directed to the child welfare sector. The recommendations were content analyzed using an inductive approach (Berg, 2001). First, I read and reread the text and created a coding scheme from the themes emerging from the data. Next, graduate students met together to discuss themes for the final coding. I applied the codes and made revisions to the coding scheme as necessary.

2.3 Results

Sample Characteristics

The initial sample consisted of 241 cases of domestic homicide. Cases that did not meet the criteria for inclusion (cases with female perpetrators, same-sex couples, children over the age of 18, and perpetrators over the age of 65) were removed to allow for meaningful analysis. In addition, cases where it was unclear if the victim or perpetrator had contact with the children prior to the homicide, or where the age of the child(ren) was unclear were removed. This resulted in a final sample of 191 cases of domestic homicide that occurred from 2003-2016. In this sample, 9.4% (n = 18) of the cases involved children who were killed [*Child Target*], 46.6% (n = 89) involved cases where children under the age of 18 were present in the family system but not

killed [*No Child Target*], 19.4% (*n* = 37) involved cases where the couple had no children in the family system [*No Child in Family System*], and 24.6% (*n* = 47) of the cases involved children who were either over the age of 18 or had no contact with the victim or the perpetrator [*Child over 18 or No Contact with Victim or Perpetrator*].

Table 1**.** *Characteristics of Domestic Homicide Cases*

	Child Target	No Child Target	No Child in Family System	Child over 18 or no contact with victim or perpetrator	Total
	n (%)	*n (*%)	*n (*%)	*n (*%)	*n (*%)
Total Cases	18 (9.4)	89 (46.6)	37 (19.4)	47 (24.6)	191 --
Type of Case					
Homicide	5 (27.8)	45 (51.1)	21 (56.8)	27 (57.4)	99 (51.8)
Homicide-Suicide	4 (22.2)	38 (43.2)	16 (43.2)	16 (34.0)	74 (38.8)
Multiple Homicide	3 (16.7)	3 (3.4)	0	1 (2.1)	7 (3.7)
Multiple Homicide-Suicide	6 (33.3)	2 (2.3)	0	3 (6.4)	11 (5.8)
Relationship Status					
Legal Spouse	5 (27.8)	32 (36.4)	7 (19.4)	18 (39.1)	63 (33.0)
Estranged Legal Spouse	10 (55.6)	20 (22.7)	3 (27.8)	6 (13.0)	41 (21.5)
Common-Law	1 (5.6)	19 (21.6)	7 (19.4)	11 (23.9)	38 (19.9)
Estranged Common-Law	1 (5.6)	4 (4.5)	3 (8.3)	2 (4.3)	10 (5.2)
Dating	0	3 (3.4)	3 (8.3)	6 (13.0)	12 (6.3)
Estranged Dating Relationship	1 (5.6)	10 (11.4)	13 (36.1)	3 (6.5)	27 (14.1)

Of this sample, there were a total of 107 cases where children were present in the family system. More than one-quarter of the children (28%) observed the fatal incident (*n* = 30; 57% did not; unknown in 15% of the cases), and 26.2% of the children were directly involved in the fatal incident (*n* = 28).

Service Provider Involvement

Multiple service providers were involved with the cases prior to the homicide. An independent samples *t*-test was conducted to determine if differences existed between the type of child case and number of service providers/agencies the family was involved with prior to the homicide. There was no significant difference in the average number of agencies involved in cases where children were killed compared to cases where children were present but not killed.

The child protection system was involved at some point in the history of the family in 12% of the cases overall (n = 23) and 21.5% of the cases where there were children under the age of 18 in the family system (n = 23). There were no significant differences in the involvement of the child protection system in cases where children were killed and cases where children were present in the family system but not killed χ^2 (1) = 1.46, p >.05. In all cases involving children, police were involved in approximately half of the cases. Interestingly, CPS was involved in less than half of the cases with police involvement. Due to limited information in the case summary reports about the CPS and police communication between the cases, it remains unclear what CPS investigations, or interventions, were undertaken when CPS received a report from the police about an occurrence of DV. There is also the possibility that the police responded to a complaint about DV but did not determine they had a duty to report to CPS, potentially contrary to their policy.

Table 2. *System Contact of Cases Involving Children*

	Child Target		No Child Target		Total	
	n	%	*n*	%	*n*	%
Total Cases	18		89		107	
Child Protection Services						
No	11	61.1	62	69.7	73	68.2
Yes	6	33.3	17	19.1	23	21.5
Unknown	1	5.6	10	11.2	11	10.3
Police						
No	7	38.9	37	41.6	44	41.1
Yes	10	55.6	43	48.3	53	49.5

Unknown	1	5.6	9	10.1	10	9.3

CPS Involvement in Cases Regardless of Child Outcome

The relationship between involvement with child protection services and number of agency contacts was analyzed using an independent t-test. Results indicated that there were a significantly higher number of total agencies involved with both the victim and perpetrator for cases that had contact with CPS (M = 9.37, SD = 5.47) compared to cases that had no contact with CPS (M = 4.94, SD = 3.56); t (87) = -4.24, $p < .001$.

Analyses were completed to determine if there were differences in the CPS-involved cases and contact with specific professionals who had knowledge of the DV prior to the homicide. A chi-square test of independence was conducted to determine if the police knowledge of DV was associated with child protection services contact. A significant association was found between police reports of DV and child protection services, χ^2 (1) = 12.73, p <.001. The majority of cases with police contact did not have contact with CPS, though most CPS cases had prior police involvement. However, 43% of the cases had no contact with either CPS or police. Further, chi-square analyses revealed a significant association between DV shelter contact and CPS, χ^2 (1) = 10.47, p <.001. Chi-square analyses were conducted with other service providers/agencies that had knowledge of DV within the family. Courts, medical professionals, legal council, and social service agencies revealed no significant associations with CPS contact.

Risk Factors and CPS Involvement

Number of DVDRC risk factors. The relationship between involvement with child protection services and number of risk factors was analyzed using an independent t-test. Results indicated that there were a significantly higher number of risk factors in cases that had contact

with CPS (*M* = 15.17, *SD* = 5.38) compared to cases that had no contact with CPS (*M* = 11.14, *SD* = 5.43); *t* (94) = -3.12, *p* <.01. In both CPS and non-CPS involved cases, there was a high number of risk factors.

Type of risk factors. Cases that had CPS involvement and cases that had no CPS involvement were compared on 38 risk factors identified by the DVDRC using chi-square analyses. There was insufficient information regarding the history of DV in previous relationships (perpetrator), thus analyses were not conducted. Chi-square tests of independence revealed significant associations between CPS contact and 'prior threats to kill the victim', χ^2 (1) = 4.83, *p* <0.05; 'perpetrator history of violence outside family', χ^2 (1) = 5.10, *p* <0.05; and 'perpetrator was abused or witnessed DV as a child', χ^2 (1) = 4.16, *p* <0.05. The presence of these risk factors appeared more frequently in cases that had CPS involvement. Post hoc analyses were conducted using adjusted standardized residuals and an alpha level of .001 with the Bonferroni correction. No significant differences were found for any of the aforementioned risk factors (p > .001).

Results indicated no significant associations between CPS involvement and the following 21 risk factors: prior threats with a weapon against victim; prior suicide attempts/threats (perpetrator); prior attempts to isolate victim; controlled most or all of victim's daily activities; escalation of violence; perpetrator unemployed; obsessive behaviour displayed by perpetrator; victim and perpetrator living common-law; presence of step-children in the home; extreme minimization and/or denial of spousal assault history by perpetrator', and 'new partner in victim's life either real or perceived'; excessive alcohol and/or drug use by perpetrator; perpetrator depression in opinion of professionals and non-professionals; other mental health/psychiatric issues; access to or possession of firearms; perpetrator failure to comply with

authority; perpetrator was violently and constantly jealous of victim; misogynistic attitudes; age disparity between couple of 9 years or more; victim's intuitive sense of fear; and history of violence or threats against children.

Twelve risk factors did not meet the chi-square assumption of less than 25% of cells with an expected count less than five and were instead subjected to Fisher's exact test. History of DV in current relationship; prior destruction of property of victim's property; prior assault with a weapon against victim; choked victim in past; prior hostage taking or forcible confinement; forced sexual acts and/or assaults during sex- perpetrator; prior assault on victim while pregnant; child custody or access disputes; prior violence against pets (perpetrator); actual or pending separation; history of suicidal behaviour in perpetrator's family; and youth of couple were not found to be significant.

Formal risk assessment. A large portion of the cases were missing information on whether or not a formal risk assessment was conducted (n=45, 42.1%). Of the cases where it was known, 87% of the cases did not have a formal risk assessment documented by any of the systems involved (n = 54; n = 8, 13% had formal risk assessment). Fisher's exact test was conducted to determine if there were differences in CPS involvement and cases with a known formal risk assessment. A significant association was found, χ^2 (1) = 7.35, p <.01, such that a formal risk assessment was present more often in cases with CPS contact compared to cases with no CPS contact. No significant associations were found with CPS contact and a risk assessment leading to safety planning and a risk management strategy. However, the risk factor 'after risk assessment, perpetrator had access to victim' was found to be significant with a corrected alpha level, χ^2 (1) = 13.2, p <.001. CPS involved cases had a higher frequency of the perpetrator having access to the victim after a risk assessment than non-CPS involved cases. However, there

were a significant number of missing cases in the risk assessment variable and results must be interpreted with caution.

DVDRC Recommendations to Child Welfare Sector

The DVDRC has advantageously used hindsight to suggest what could have been done in each case with the goal of preventing future domestic homicides. Over the years, a number of recommendations were developed to inform the policies and practices within the child welfare sector in Ontario. The recommendations specific to the child welfare sector comprised five main themes: (1) enhanced screening for DV; (2) specialized DV training; (3) increased cross-sector collaboration; (4) enhanced ongoing service provision; and (5) amendments to internal policies/protocols.

Table 3. *Themes from DVDRC Recommendations to Child Welfare Sector*

Enhanced screening for domestic violence
• Universal enhanced screening • Changes to tools to code for lethality in DV cases
Specialized DV training
• Risk factors for lethality • Effective intervention promoting safety of mothers and children & holding abusers accountable • Increased skill and comfort level in working with abusers
Increased cross-sector collaboration
• Protocols with family law sector, social service sector (including children's counsellors and batterer intervention programs)
Enhanced ongoing service provision
• High-risk teams • Improved quality assurance measures • Enhance standards for CAS interventions specifically with perpetrators
Amendments to internal policies/protocols
• Mandatory internal death review for cases where parent or child was involved with CAS in past year

Enhanced screening for domestic violence. Several recommendations highlight the need for the child welfare sector to do an enhanced screening with all calls received related to domestic violence, and to interview all partners involved as part of this process. When there is evidence of DV, the child welfare sector must use their authority under the provincial legislation to employ appropriate interventions with the perpetrator to protect the mother and child. Along with this, the DVDRC has recommended that the child welfare sector enhance their screening tools to add a code for a risk of lethality in cases of partner conflict. Moreover, the recommendations reiterated that screening and risk assessment is not an end in and of itself, but rather a continuing process that informs coordinated and appropriate risk management and safety

planning. Special attention is made in assessing the potential danger posed to children during separation.

Specialized DV training. The second theme of recommendations focuses on enhancing the level of training CPS workers received regarding DV. The DVDRC recommended that CPS workers receive ongoing training in the following areas: awareness and identification of risk factors for lethality; utilization of a standardized risk/danger assessment tool in cases of DV; effective intervention that enhances safety of mothers and children and holds perpetrators accountable; opportunities to increase skill and comfort in directly intervening with perpetrators on risk reduction; and enhanced understanding on the risks for children having access with perpetrators who remain untreated.

Increased cross-sector collaboration. The work of the DVDRC often identifies a lack of collaboration amongst professionals involved with the family prior to the homicide. This theme of recommendations emphasizes the importance of increased collaboration between the child welfare sector and law enforcement, VAW, family law, healthcare, education, corrections, and social services (i.e., batterer intervention programs). The DVDRC recommended the child welfare sector develop protocols with several sectors to allow for information sharing regarding safety planning and adoption of a universal standardized risk assessment tool. Specifically, the child welfare sector should establish a protocol with the family law governing body to increase provisions for child safety in DV cases in the context of separation. The child welfare and VAW sector have an established collaboration policy and it was recommended that agencies continue to follow this. On a larger scale, the DVDRC recommended increased collaboration with the governing body of professionals working with children and youth to develop protocols for structured information sharing regarding risk and safety for children.

Enhanced ongoing service provision. Several recommendations were made to improve the ongoing service provision with victims and perpetrators. Consistent with cross-sector collaboration, the DVDRC recommended the implementation of case conferencing or the establishment of high-risk teams consisting of partners from the justice, health, VAW, and mental health fields to coordinate and share information regarding safety in high-risk cases. Further, reviews of cases highlighted the need for the child welfare sector to ensure that best practices and standards of care for interventions are maintained. Lastly, it was recommended that standards of care for interventions directed at perpetrators should be enhanced to ensure that DV perpetrators participate in approved batterer intervention programs before permitting unsupervised visits or terminating CPS involvement.

Amendments to internal policies/protocols. Finally, in an effort to increase their understanding of missed opportunities in homicide cases, the DVDRC recommended the child welfare sector conduct internal death reviews on domestic homicides where the parent or child was involved with CAS within the year prior and it was known that DV had been present. The goal from these reviews would be to allow the sector to learn from these cases and implement changes to prevent future tragedies.

2.4 Discussion

The nature of the child protection intervention in a case prior to a domestic homicide has seldom been the subject of research. The purpose of the current study was to examine the nature of child protection services involvement with families prior to a domestic homicide. Additionally, the major areas of recommendations directed to the child welfare sector by the DVDRC were examined. This research examined 107 domestic homicide cases reviewed by a

multidisciplinary death review committee to investigate child protection services involvement, and other factors that were present in the case prior to the homicide.

Overall, CPS were involved with only 21.5% of the homicide cases where children were present in the family system. Results indicated no differences in CPS involvement in cases where children were killed, compared to cases where children were present but not killed. Cases with children that were involved with CPS differed very little from cases without CPS involvement. They did have a higher number of DVDRC risk factors compared to cases that were not involved. A few DVDRC risk factors and related variables were present more often in cases with CPS involvement, namely: formal risk assessment completed, and after the risk assessment the perpetrator had access to the victim. Analyses examining CPS involvement and other service agencies revealed that cases with CPS contact had a higher number of total agencies involved. However, the majority of cases with police contact did not have contact with CPS. Lastly, DVDRC recommendations to the child welfare sector highlighted the need for enhanced screening for DV, specialized DV training, increased cross-sector collaboration, enhanced ongoing service provision to promote child/victim safety, holding perpetrators accountable, and amendments to internal policies/protocols following a DV-related death in child welfare populations. The outcomes in the analyzed cases reflect missed opportunities to focus on risk assessment and to utilize the information gleaned to inform risk management and safety planning efforts.

The challenges child protection workers face in working with DV cases are well-documented (Alaggia et al., 2007; Fusco, 2013; Hughes & Chau, 2013; Mandel, 2010; Mills et al., 2000; Shlonsky & Friend, 2007). Barriers include the reluctance of victims to disclose or

seek services, sectors operating in siloes, increased demand for services, higher frequency of surveillance of mother, and decreased accountability of perpetrators (Alaggia et al., 2007).

In the current study, few of the cases had child protection involvement prior to the homicide. Given that approximately half of the cases had contact with police who knew about the DV and that police services have a duty to report to CPS, the lower frequency of contact with CPS was surprising. Factors that might explain this finding include police not reporting the incident to the CPS because they reasoned the incident was not serious enough, or because there were no children present at the scene. If a report was made by police, CPS may have screened it out based on the perceived minor nature of the DV or as a result of determining the victim parent could adequately protect the children. For example, CPS might close a file at the point of investigation if the parents separate and the victim parent is seen to be protective and taking action to seek custody with a safe separation plan. The nature of the communication between police and CPS varies in communities (i.e., dependent on whether charges are laid, varying methods of notification, such as direct call or faxed referrals) and some research suggests an inconsistency in the amount of standard information in police notifications to CPS (Stanley, Miller, Richardson Foster & Thomson, 2010). It was beyond the scope of the database to examine the details of the contact between the police and CPS.

Risk factors in cases involving child protection services. Although CPS and non-CPS involved cases both had a high number of risk factors, it is still important to note that significant risk factors were present in CPS cases. This could possibly suggest that the cases were more complex and higher-risk in general. This aligns with previous research that parents who committed severe or fatal abuse were often known to CPS prior to the incident and had higher rates of DV and substance abuse (Famularo et al. 1992; Mills et al., 2000). Without having

access to detailed CPS case files for this study, it was difficult to determine if there were missed opportunities to assess and manage risk, including the use of child protection legislation to limit contact with the perpetrator posing the risk.

Concerning specific risk factors, the presence of almost all risk factors did not differ significantly between CPS and non-CPS cases. The only exception was the risk factor that ascertained perpetrator contact following a risk assessment, whereby it was found that perpetrators had access to victims in cases involved with CPS. There was little information available regarding the risk assessments performed, including who completed the risk assessment, the level of risk identified, and whether or not there was adequate risk management to address the risks. Risk assessment goes hand-in-hand with a coordinated community response to manage the risks identified (Stanley & Humphreys, 2014). When CPS knows of a history of violence, it is of utmost importance to manage the risk that the perpetrating parent poses to children's safety, even if the partners have separated.

The overall findings indicated that a significant percentage of cases (43%) had neither CPS nor police involvement. Previous research has indicated that DV victims with children experience barriers seeking help from formal supports due to fears of significant repercussions (Ansara & Hindin, 2010; Fugate, Landin, Riordan, Naureckas & Engal, 2005; Rhodes, Cerulli, Dichter, Kothari & Barg, 2010; Sylaska & Edwards, 2014). Moreover, findings indicated that the CPS involved cases had a higher number of agencies involved, suggesting that there were potential missed opportunities for collaborative risk assessment or management. Drawing on the exposure reduction framework, a retaliation effect may have existed for these families as the little or ineffective resources may have increased the perpetrators aggression without appropriately reducing exposure (Dugan et al., 2003). When service involvement is ineffective

and lacks the collaborative recognition and management of lethality risk factors, children remain in harms way.

Risk assessment. Few cases had a formal risk assessment (as defined by using a known DV risk/lethality assessment tool) completed. Of those that did, many had CPS contact. It also appeared that following a formal risk assessment, perpetrators had access to victims more frequently in CPS involved cases. However, it was unclear from the information available whether or not the use of formal risk assessment sufficiently informed safety planning and risk management. It would be important to consider the role CPS plays in reviewing the nature of perpetrator access when formal risk assessment reveals a high risk for lethality.

Practice Implications

Research on domestic homicides reveals valuable information regarding lessons that can be learned from tragedies. In this study, findings highlighted that the perpetrators involved with CPS made threats to kill the victim and had a history of violence outside of the family. Previous research has indicated that CPS workers experience challenges in intervening directly with the perpetrator to reduce risk and hold them accountable (Bourassa et al., 2006), however they are in a unique position to intervene with fathers/perpetrators, particularly as it relates to child lethality risks. Enhancing the child protection response to fathers perpetrating domestic violence is an important future direction that is supported by the findings in this study.

Further, the recommendations from the DVDRC strongly emphasize increased measures to properly assess all parties involved with DV and not just focus on the adult victim. On a positive note, changes have been made to the screening tools (Ontario Eligibility Spectrum, 2016) utilized across the province to include the assessment of risk for lethality of children in the context of DV (Ontario Ministry of Child and Youth Services, 2016).

The DVDRC has recommended the child welfare sector conduct internal death reviews on domestic homicides where the parent or child was involved with CPS in the year prior because of a concern that DV was present. It would be important for CPS to consider this recommendation and institute a practice of internal case reviews such as the ones they are required to do for other types of child deaths. In this way, a more detailed analysis of interventions with the family can then inform future risk management practices and can be disseminated to CPS and DV sector providers in the province.

Importance of collaboration. Findings indicated that CPS-involved cases had a higher number of other agencies involved. This speaks to the possibility that there were opportunities for collaboration in risk reduction. The current study highlighted the need for increased cross-sector collaboration, a finding that is reiterated throughout the literature (Coulter & Mercado-Crespo, 2015; Jenney et al., 2014; Mandel, 2010; Shlonsky & Friend, 2007; Stanley & Humphreys, 2014). Recent revisions to the Ontario child protection training system now include a two-day domestic violence course that will be jointly facilitated and delivered to a CPS and DV sectors audience (Ontario Association of Children's Aid Societies, 2019). The curriculum includes segments on risk assessment/management, engaging fathers in addressing child protection concerns and recognizing the impact of exposure to domestic violence on children. The expectation is that this training will emphasize a common understanding of risk assessment processes and will encourage community collaborations through relationships developed in the training environment.

Future Research

Given the significant role service providers can play in preventing domestic homicide, it is important that future research continues to examine the system response to DV. Our findings

indicated that less than one-quarter of the cases were involved with CPS, and future research must examine help-seeking barriers perceived by victims, as well as those barriers identified by service providers. Research is needed on the competence and effectiveness of CPS interventions in DV cases through child protection system case audits on case data and outcomes. Additionally, formal risk assessments were completed in a small number of cases, and it was unclear if CPS was involved with these assessments. The child welfare sector in Ontario has a number of mandated safety and risk assessment tools, but they are not specific to DV lethality risk. An area for further investigation is in the evaluation of the tools and determining the validity of these tools in cases involving DV. Risk assessment is not an end in and of itself, and it is important to elucidate if the risk assessment tools were helpful in developing safety plans.

Limitations

Although this sample provides a rich source of data from domestic homicides, there were limitations to its use. The following limitations should be taken into consideration when drawing conclusions:

This study utilized secondary data from a retrospective case-based dataset that used homicide reports and interviews to identify the presence of risk factors. This type of data source and research design can be prone to validity issues, such as biases and errors in reporting, due to the reliance of individual interpretation when coding for the presence of variables. While the data obtained from the DVDRC are very informative, case reports are created for the purpose of the Coroner's review, which is an inherent limitation. Relevant qualitative information and detail that may be important to understand the dynamics of domestic homicide and previous agency involvement may have been omitted or missed as it was outside of the scope of the Coroner's report. It cannot be confirmed whether missing information was excluded because it did not meet

the criteria for the report or if it was absent in a particular case. This made it difficult to draw conclusions and may have skewed the data by providing an incomplete picture. The limited data in case reports are often subject to the researcher's interpretation and may not be an accurate reflection as researchers are forced to draw conclusions. Moreover, there was extremely limited data regarding the details of agency involvement. Lastly, the data set did not allow for an examination of the interactions among the risk factors (only one at a time or as a total amount) due to the small sample size and low case rate indicators.

It was beyond the scope of the data to determine the appropriateness/effectiveness of the actions taken by CPS and other service providers involved with the family (police, VAW, legal professionals). While there is a protocol between CPS and police, it was unclear if the protocol was implemented on a consistent basis by the police (i.e., report not made to CPS if child not present at time of DV occurrence). Further, even if a report was received by CPS, it was unclear of the direction that CPS took and how they operationalized the information received from police.

Further, domestic homicide is a rare occurrence and the dynamics of this specific phenomenon may not extrapolate to other populations. There were no comparisons drawn to CPS-involved cases that did not end in homicide. There can be no certainty that another intervention by CPS and other community agencies would have changed the course of the homicide. As well, the DVDRC recommendations have developed over 13 years and it would be difficult to establish if current CPS practices have changed over time. This study involved a limited sample size of only Ontario domestic homicide cases, which was further reduced by certain exclusionary criteria and missing data. As such, this reduced the power to detect effects. Ideally, it would have been good to examine regional differences (urban compared to rural) as

well as interventions with vulnerable populations (e.g., Indigenous, immigrants/refugees) if there had been a larger sample.

Conclusion

Any death from a domestic homicide has a catastrophic impact. The outcomes in the analyzed cases reflect missed opportunities to focus on risk assessment and to utilize the information gleaned to inform risk management and safety planning efforts. Given that domestic homicides appear to be somewhat predictable and potentially preventable with hindsight, it will be important to continue efforts to engage communities to develop awareness and increase cross-sector collaborations to assess and manage risk. Further, a focus on enhancing CPS involvement with risk assessment and management is an important area for future study. Continued efforts to improve system responses to DV hold the hope that there will be a significant reduction in domestic homicides.

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Chapter 3

Ontario Child Protection Workers' Views on Assessing Risk & Planning for Safety in Exposure to Domestic Violence Cases

Abstract: The use of standardized tools to assess risk for a child is mandatory in the child protection sector in Ontario. However, factors specifically assessing the risk of lethality in exposure to domestic violence (DV) cases are largely overlooked in these tools. Using data from an online survey of 138 child protection workers in Ontario, this study examined practitioners' risk assessment and safety planning practices with DV cases. Findings provided an overview of the frequency of risk assessment and management strategies within various environmental contexts (e.g., urban, rural) and populations (e.g., Indigenous, immigrants/refugees). Assessing and managing risk was frequently and consistently completed across the province; however, the specific strategies and identified challenges varied. While mandatory provincial child protection tools were the most commonly used structured tool, some workers reported using other standardized risk assessment tools (i.e., Danger Assessment, B-SAFER) to complement their own measurement of risk and planning for safety in higher-risk cases. Respondents emphasized the importance of working collaboratively with families and professionals in other sectors to address risk. Implications for future research include exploring specific provincial child protection risk assessment processes, the barriers and challenges of using DV specific risk assessments in child protection, and factors contributing to these challenges identified by practicing child protection workers.

3.1 Introduction

Domestic violence (DV) is a serious public health and social concern that can result in homicide (World Health Organization, 2013). DV impacts the family system – not only the victim parent but also the developing child, and the caregiver-child relationship (Wendt, Buchanan & Moulding, 2015). Children living with DV can have serious adverse impacts on their overall well-being. Estimates indicate that over half of victims of DV in Canada have children who witnessed incidents of violence (Kaukinen, Powers & Meyer, 2016). In rare cases, children may be harmed or killed as a result of DV, either being caught in the crossfire or as an act of revenge against the primary victim. There are often many risk factors or warning signs prior to a domestic homicide, and formal agencies and informal supports can recognize these and intervene. Suspecting or knowing that a child is living with DV may be considered a form of emotional harm, or may indicate a risk of physical harm, thereby triggering a mandatory report to child protection services (CPS). Recent death reviews have pointed to the critical role of CPS in keeping children safe as they are the only mandated service to protect children. Given the serious consequences of living with DV, there is a need for an enhanced CPS response to assessing risk in DV cases. This paper focused on gaining a clearer picture of the risk assessment and safety planning strategies used by Ontario child protection workers when DV is a primary concern.

Exposure to Domestic Violence as a Form of Child Maltreatment

Exposure to DV (EDV) is one of the leading reasons for reporting to child protection across Canada (Public Health Agency of Canada, 2010). In Ontario, the role of child protection services in cases where children are living with DV is to determine if those children are at risk of harm and in need of protection. The execution of this role may vary widely across jurisdictions.

In Ontario, the *Child, Youth and Family Services Act* outlines what constitutes child abuse and neglect. There is no specific clause in the *CYFSA* that explicitly identifies exposure to DV as a reason to find a child in need of protection (CYFSA, 2017). However, child protection concerns related to DV can be addressed through the clauses 'physical harm or risk of physical harm' (74.2.b) and 'emotional harm or risk of emotional harm' (74.2.f1; CYFSA, 2017). While the legislation does not specify DV as a reason to find a child in need of protection, child protection provincial standards do outline DV as a risk.

Children's Aid Societies in Ontario have the exclusive mandate by the *CYFSA* to protect children and youth who have been, or are at risk of being, abused and/or neglected by their caregivers, to provide for their care and supervision where necessary and to place children for adoption (CYFSA, 2017). Following a report of suspected child abuse or neglect by a professional or community member to the local Children's Aid Society, a child protection worker (CPW) assesses each report based on the *Child Protection Standards* and the O*ntario Child Welfare Eligibility Spectrum.* The CPW discerns if there are "reasonable and probable grounds that a child may be in need of protection," and if so, an investigation occurs (Wegner-Lohin et al., 2014). The investigation is either completed using the following: (1) a "traditional approach" (focused on ascertaining facts and collecting evidence in a legally defensible manner); or (2) a "customized approach" (utilizes a more flexible, individualized approach in less severe cases; Wegner-Lohin et al., 2014). If it is deemed that abuse has been substantiated, and as a result a child is in need of protection, child protection workers will open the case for ongoing services.

Assessing for risk in cases of EDV in child protection. Extensive research has been conducted on child protection practice and interventions with families experiencing DV (Button

& Payne, 2009; Cross, Matthews, Tonmyr, Scott, & Ouimet, 2012; Hughes & Chau, 2013; Hulbert, 2008; Lapierre & Côté, 2011; Lavergne et al., 2011; Jenney, 2011; Mills et al., 2000; Pennell, Rikard & Sanders-Rice, 2014; Postmus & Merritt, 2010; Radford, Blacklock & Iwi, 2006; Shlonsky & Friend, 2007). Historically, child protection services have focused their interventions on reported concerns directly related to children being harmed (e.g., physical or sexual abuse allegations or neglect). In recent years, there is recognition that living in a home where DV is occurring can place children at risk of harm, with rates of co-occurrence of EDV and other forms of child maltreatment commonly cited between 60 to 75 percent (Wathen & MacMillan, 2013). However, professionals in child protection may not always accurately identify the presence or severity of DV (Bourassa et al., 2006; Kohl, Barth, Hazen, & Landsverk, 2005; Rivers, Maze, Hannah & Lederman, 2007). In fact, the child protection sector has been criticized for lacking guidance on both the methods and timing of child welfare interventions in cases of EDV (Edleson, Gassman-Pines, & Hill, 2006).

Although not the focus of this study, it is important to note that child protection interventions in EDV cases tend to centre on the mother, who is seen as the protective parent and solely responsible for ending the violence (Jenney, Mishna, Alaggia & Scott, 2014; Douglas & Walsh, 2010). As such, some women may be faced with an ultimatum to leave their partner to keep the children or remain with their partner and lose their children. This pervasive trend is documented in the literature as being ill-conceived and oppressive toward mothers (Alaggia, et al., 2015; Humphreys & Absler, 2011; Magen, Conroy, Hess, Panciera & Simon, 2001).

Further, failing to differentiate the context of DV within intimate partner relationships may have an impact on the assessment of risk and focused interventions (Douglas & Walsh, 2014). Child protection safety interventions tend to focus on requiring the mother to separate

herself from the abusive intimate partner regardless of whether such actions are disruptive to the children. Most importantly, without an assessment of the risk for lethality, a separation can be the trigger for further serious abuse or even death. Various factors may exist as obstacles to child protection workers effectively detecting DV and intervening in families, including: parents' denial, lack of evidence, heavy workloads of workers, lack of cooperation by parents, short duration of interventions, and parental substance abuse (Bourassa et al., 2006; Kohl et al., 2005). Failing to understand these obstacles to accurately identify DV has implications for assessing the risk for lethality that children may face. Research has demonstrated that issues related to identifying and responding to DV are structural in nature, and often go beyond the attitudes and practice of individual workers (Humphreys, 2010; Szilassy, Carpenter, Patsios, & Hackett, 2013). Button and Payne (2009) suggest an approach that focuses on both macro-level characteristics and micro-level factors when identifying and assessing DV. It has been articulated that honing in too narrowly, or erroneously identifying the type and cause of DV, may in fact expose victims to further risk (Button & Payne, 2009). Thus, risk assessment in the context of DV needs to consider factors identified to be associated with higher risk of lethality or recidivism. Often, this assessment of risk can be guided through the use of structured tools.

***Standardized assessment tools in child protection*.** Research conducted within child protection systems has demonstrated that a significant number of children under protective supervision are exposed to DV; however, screening and investigation of the violence is often insufficient (Hazen, Connelly, Kelleher, Landsverk & Barth, 2004). Alarmingly, in Ontario, there are no standardized tools within child protection services that specifically assess for the risk of child lethality in the context of DV (Ontario Ministry of Children and Youth Services, 2016). The Ontario Ministry of Children and Youth Services outlines risk assessment tools as per the

Ontario Child Protection Standards. The tools include Safety Assessment, Family Risk Assessment, Family and Child Strengths and Needs Assessment, Family Risk Reassessment, and Reunification Assessment Tools (Ontario Ministry of Children and Youth Services, 2016).

These assessment tools utilized in child protection are not specific to lethality risks posed by DV (Jenney, 2011; Shlonsky & Friend, 2007). DV may be one factor that child protection workers consider as part of their standards of practice for assessment, but DV as a single risk factor may not influence their decision making (Hughes & Chau, 2013). While child protection workers may base their assessments and interventions on factors typically included in risk assessment tools, their process for assessing risk to children involves engaging in a complex decision-making process with attention to how the violence impacted the children, along with the caregivers' willingness to accept responsibility and make changes (Hughes & Chau, 2013). In their review of the literature on the utility of risk assessment tools in the context of child maltreatment and DV, Shlonsky and Friend (2007) articulate that good risk assessment instruments are better with prediction than clinical judgment, though the worker plays a crucial role is assessing the dynamic context of child maltreatment and DV. Standardized risk assessment tools for DV have not been normed on populations involved with child protection, which impacts the validity and reliability of their usage within this sector.

Furthermore, some have argued that the skills and abilities of the child protection worker influences the assessment of risk in families where there is DV (Jenney et al., 2014; Kohl et al., 2005; Postmus & Merritt, 2010; Radford et al., 2006; Shlonsky & Friend, 2007). Personal (e.g., demographic characteristics) and professional (e.g., prior case experience, agency policies and protocols) factors can influence a child protection worker's beliefs about DV and subsequently their response (Postmus & Merritt, 2010). Research with both survivors of DV involved with

CPS and child protection workers emphasized the importance of rapport building in being able to adequately assess risk and plan for safety (Jenney et al., 2014). One study of various social service workers found that while child protection workers had more knowledge of DV than other workers, child protection workers had insufficient knowledge about communicating warning signs for lethality and effective interventions with perpetrators (Button & Payne, 2009). Moreover, depending on how the level of risk to the child is conceptualized (i.e., directly or indirectly harmed, physically or emotionally), child protection workers may not remain involved with the family and miss the opportunity to address ongoing dynamic risk factors (Hughes & Chau, 2013).

Best practices for assessing risk for lethality within child protection have not been well-documented in the literature and may, in fact, not be well-developed and vary across communities. Additionally, the field of child protection has experienced barriers in implementing services in DV cases that maintain the notion that safety for the mother is synonymous with ensuring safety for the children (Hughes, Chau, & Poff, 2011; Shlonsky & Friend, 2007). And ironically, while the intervention taken in many child protection investigations involving DV is to require the mother to separate from the abuser, some research suggests that the child protection system may even be reluctant to become involved in cases where parents with an alleged history of DV are separated and in dispute over custody or access, for fear of being drawn into the dispute by conflicting allegations (Lessard et al., 2010).

Current Study

Given the high incidence rates of exposure to DV in child welfare populations, the practice of assessing risk to children is a necessary component in child protection work. The assessment of risk in cases of DV is crucial to adequately inform safety planning efforts.

Historically, child welfare interventions in DV cases have been criticized for narrowly focusing on interventions with mothers to protect children and often failing to recognize the safety and emotional needs of victimized mothers (Magen et al., 2001). Research has identified the need for strengths-based approaches that are less focused on maternal deficits and imposing safety plans through partner separation, and more on mitigating risk that perpetrators pose (Jenney, Mishna, Alaggia, & Scott, 2014).

While legislation identifies exposure to partner violence as a form of child maltreatment under emotional harm, there are limited directives to implement clear policies and protocols for intervening and assessing risk specific to DV (Nixon, Tutty, Weaver-Dunlop & Walsh, 2007). Even though there has been discussion of this issue for over a decade, cases continue to be reviewed by the Ontario DVDRC that note the importance of risk assessment and effective risk management (Ontario DVDRC, 2018). As such, the nature of risk assessment and management varies considerably across jurisdictions and organizations. Some researchers have argued that the dominant discourse on assessing and managing risk in DV cases too often emphasizes the need for separation while failing to hold perpetrators accountable. Furthermore, there is a scarcity of research examining the use of risk assessment tools in CPW in Ontario.

The purpose of this paper is to better understand the nature of DV risk assessment and risk management within the child protection sector by examining the following: (a) the frequency with which Ontario child protection workers engaged in risk assessment practices; (b) types of risk assessment tools child protection workers use; and (c) child protection workers' self-reported experiences with assessing risk in the context of DV.

3.2 Method

The present study utilized a subset of data from the second phase of an ongoing Social Sciences and Humanities Research Council (SSHRC) funded research initiative entitled *Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations* (CDHPIVP). The project aimed to identify promising practices in the prevention of lethal domestic violence with four vulnerable populations: immigrants and refugees; rural, remote and northern populations; Indigenous peoples; and children exposed to domestic violence. It consisted of three phases: (1) a systematic literature review; (2) an online survey and interviews with professionals in the field; (3) interviews with both survivors of severe domestic violence and proxies (individuals knowledgeable about the victim's relationship with the perpetrator) of domestic homicide. This study focused on the second phase, which aimed to gain a deeper understanding from professionals in various sectors, of barriers in effectively assessing and managing risk, and safety planning, in cases of domestic violence.

Questions in this survey were broad in scope and focused on the type of practices professionals across different sectors engage in. These questions were created and reviewed by researchers and experts in the field and were exploratory in nature. Additionally, definitions were created and provided on the survey for each corresponding question. These definitions were developed by national experts in the field. The survey was distributed and promoted through the partners and collaborators of the CDHPIVP. The survey was available in both official languages of Canada (i.e., English and French) and was hosted on the *Qualtrics* survey platform (qualtrics.com) for six months in 2017. Ethical approval for this proposed study was obtained through the Western University Non-Medical Research Ethics Board (Project ID: 111577).

Measures

The survey gathered demographic information from participants including the province and sector they work in (i.e., child protection, police, shelter/violence against women sectors), and population they frequently work with (children, immigrant/refugee/newcomers, Indigenous peoples, rural, remote and northern populations). Participants were also provided with definitions of risk assessment, risk management, and safety planning within the context of DV and were asked about the frequency in which they engage in these areas. Participants were also asked about their use of structured tools and provided an open-text response option to divulge the type of tools they utilize. Additionally, participants were provided the option to further comment about their experiences in the field. The survey was designed to be a conduit to recruit key informants for in-depth interviews. Participants could provide their contact information to participate in a telephone interview.

Data Analysis

Participants who indicated they worked in the child protection sector were then extracted to be the focus of the current study. Data were analyzed with descriptive statistics and chi square using SPSS 24. Open-text responses were initially analyzed using a thematic analysis (Braun & Clarke, 2006). Three senior graduate research assistants working in the domestic violence area read and re-read the responses for themes of all text-responses and groupings of types of structured tools. Graduate students met together to discuss themes for the final coding. The structured tools were then coded and transferred into SPSS for analysis for the entire sample.

3.3 Results

Sample Characteristics

In total, 1405 participants completed the survey and the majority (38.6%; n = 542) of the respondents were from Ontario, which is parallel to the provinces' proportion of the total Canadian population (Statistics Canada, 2019). Of the Ontario participants, 138 (25.5%) indicated they worked in the child protection sector. The majority reported working with urban populations, whether it be a solely urban clientele or working with both urban and rural, remote or northern populations (see Table 1).

Table 4. *Sample Characteristics for Child Protection Respondents* (*N*=138)

Type of Community Served	% (*n*)
Urban Only	27.7 (36)
Urban and Rural, Remote and/or Northern	43.1 (56)
Rural, Remote, and/or Northern	29.2 (38)

In terms of the vulnerable populations served in this sample, child protection workers reported working with various vulnerable populations. Almost all participants (99%) identified that they worked directly with children on a regular basis. While there were some slight differences observed, just under one-third of participants in this sample were found to work regularly with Indigenous peoples, and about 15% of participants regularly worked with immigrants, refugees, and newcomers to Canada (see Figure 1).

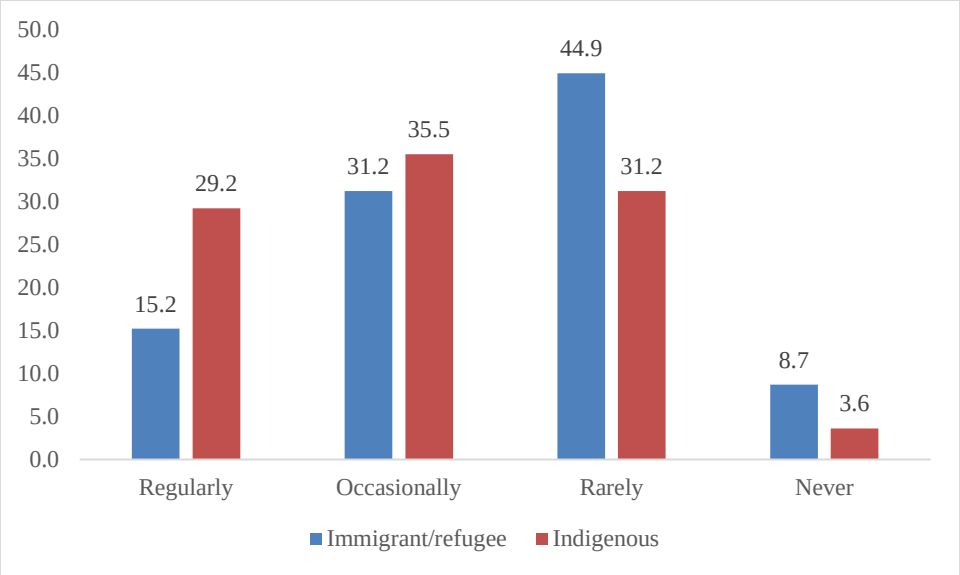

Figure 1. Frequency of Direct Work with Indigenous and Immigrant, Refugee, or Newcomer Populations

Risk Assessment, Risk Management, & Safety Planning Strategies

Child protection workers were asked about the type of strategies they engage in their response to exposure to domestic violence reports (see table 2). Overall, the large majority of child protection workers reported *frequently* assessing and managing risk and engaging clients in safety planning strategies.

Table 5. *Frequency of Risk Assessment, Safety Planning and Risk Management Strategies*

	Frequency	
	Frequently/Regularly % (*n*)	Occasionally/Rarely % (*n*)
Risk Assessment*	84.5 (109)	15.5 (20)
Risk Management	81.5 (106)	18.5 (24)
Safety Planning	85.4 (111)	14.6 (19)

**missing data n = 1*

Use of Structured Tools

Most child protection workers in this sample reported using a structured risk assessment tool in their role (85.2%, *n* = 109). There were no differences found in the relationships between the use of structured tools and the type of vulnerable populations child protection workers frequently come into contact with.

The majority of workers (90.8%) provided further information on the types of tools that they used to measure risk (*n* = 99). Overall, the majority indicated the tools used were mandated by their governing ministry (*Ministry of Children, Community and Social Services*) and were specific to child protection (see Figure 2). Most of these tools were broad in their scope in assessing for general risk of harm to children and did not focus on the risk of lethality that is specific to domestic violence. However, some workers identified that they used supplemental tools specific to domestic violence risk and/or lethality to complement their utilization of the mandatory tools. In these cases, the most frequently identified instruments were the Danger Assessment and the B-SAFER, along with tools classified as *other* (e.g., unspecified risk assessment and safety planning tools, Signs of Safety framework, Domestic Violence Screening Tool, Power and Control Wheel). However, it should be noted that the Signs of Safety is a child welfare framework that has addressed DV with greater sensitivity (Turnell & Edwards, 1999), but it is not a DV risk assessment tool. A few participants commented on their collaborative efforts with community partners in assessing risk. For example, one participant commented:

> *"Child welfare risk assessment documents are used for each case. While they identify DV as an area of risk, they focus on child safety within the context of their current caregivers. We do not use specific DV risk assessment, risk management or safety planning tools. We do work with police and the DV sector to access further risk management and safety planning resources, especially when DV high risk is identified."*

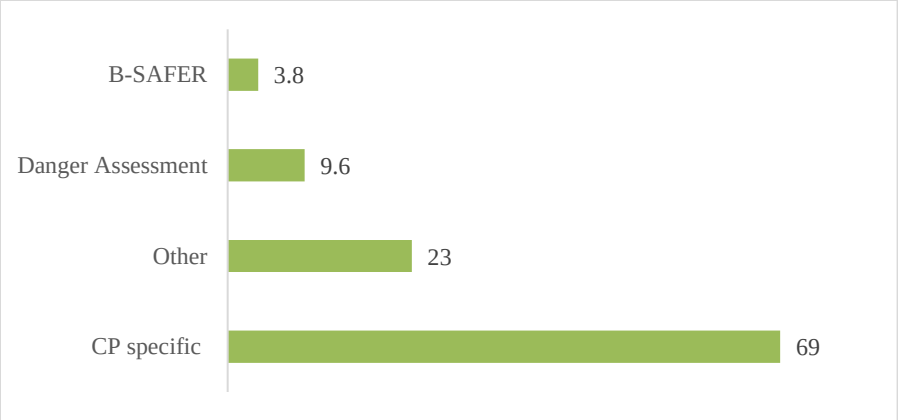

Figure 2. Types of Risk Assessment Tools Utilized by Child Protection Workers

A small number of child protection workers provided general comments on the nature of their work with exposure to domestic violence cases (n = 20; 14.5%). Three themes emerged from the comments and reflected the complex nature of their work, including the volume of DV calls and the lack of training, inadequate risk assessment tools, and the importance of collaborative risk assessment and safety planning with the family and other service sector providers.

High volume of EDV referrals and lack of training. Many commented on the high volume of cases reported due to exposure to domestic violence and expressed that given the complex nature of DV, there was a lack of training opportunities available to them. For example, one worker commented:

> *"A significant portion of my caseload is domestic violence referrals, as opposed to abuse or general neglect issues. I think the general public would be surprised how many of the investigations we do are related to domestic violence. Our safety planning is primarily related to the children in the home, but of course, also involves the victims who are often the ones caring for the children. There are few training options available for children who witness domestic violence."*

Need for more specific tools. Another theme that emerged was the need for more specific tools to guide their practice. Some participants expressed they would like more user-friendly tools: "*I would appreciate some easy-to-use tools to assess risk levels related to domestic violence."*

Other participants discussed issues with child protection specific tools. In one case, a worker discussed the drawbacks of using risk assessment tools stating, "*Tool draws heavily on historic contact with the CAS, typically causes vulnerable clients to feel defensive and upset. Safety planning - more structure would be helpful, typically I also refer to* [local women's shelter] *Community Support Services for Victims."* Many participants reported not using structured safety planning tools, acknowledging that every client had unique needs: *"[I] do not use structured safety plans because every family's needs are different."*

Participants also highlighted the inconsistency that occurs when there are no clear policies and/or procedures within their organization regarding the use of these specialized DV risk assessment tools. Best practices and tools may be introduced, but they are not embedded within the system, resulting in inconsistent use of the tools. For example, one participant stated, "*Some B-SAFER and ODARA training, but our agency does not use one specific tool, and not everyone has the training."* This particular participant also points to the lack of training on the tools within their agency.

Another participant commented on the varying use of structured tools: *"We don't systematically use structural assessments; however, we are inspired at times by the J. Campbell Danger Assessment Tool and the B-SAFER tool. We have also referenced the Jeffrey Edleson CEDV scale."* Here, it is evident that the use of DV specific tools is not required, and their use is

inconsistent. The DV specific tools are sometimes used to guide the assessment that a CPW does.

Collaboration. A final theme that emerged was the importance of collaboration— both with families and other sectors to create safety plans. For example, one worker stated, "*There is more 'buy-in' when they make the plans with us with our bottom lines",* and another indicated, "*Services plans are developed for all parties with identified goals and objectives that need to be met to ensure that there is no further exposure to conflict by the children."*

Staff highlighted the benefits of cross-sector collaborative approaches to assessing risk and safety planning. Many participants commented on collaboration with other sectors and linking families to other support services. Here, the participant points to the expertise of other professionals to help guide decision making in high-risk cases:

> *"We respond to a high volume of DV related cases, mostly referred through police. As such, our staff regularly address issues of DV and safety plan with families to reduce the impact and threat of violence toward the children. We have strong working relationships with both the police and DV sector in our jurisdiction and rely on their expertise in high risk situations."*

Specialized DV teams. Additionally, participants indicated organizational structures and practices that were promising in terms of their level of collaboration. Some agencies have adopted a specialized DV team approach in order to develop expertise within the agency related to assessing risk and safety planning with families. For example, *"*[Our] a*gency has dedicated VAW workers and an internal protocol for consults and collaboration."* Further, one participant details their comprehensive approach to cases:

> *"As a member of a specialized team that works primarily with families that are impacted by domestic violence, we have been provided with specific education and training to ensure the safety of clients (specifically children and their caregivers). While no formal assessment tools are utilized, education, safety-planning and development of a support system is regularly reviewed and discussed with clients. Information on available*

community resources is provided, and when necessary, support is provided in contacting resources and attending appointments to ensure that all safety needs are met. We also attempt to work with the abuser (most often men) and to provide education regarding the significant impact that violence and conflict has on children. We will often provide counseling support to both parents, separately and together to ensure that they are both working toward the same goals regarding safety of the children. At times, the parents want to reconcile. Service plans are developed for all parties with identified goals and objectives that need to be met to ensure that there is no further exposure to conflict by the children. In cases where there will not be a reconciliation, we provide support and information regarding the legal process."

3.4 Discussion

The current study sought to gain an understanding of child protection workers' perspectives on the processes of assessing and managing child protection risks in the presence of DV. A sample of 138 child protection workers completed an online survey regarding their risk assessment, risk management, and safety planning practices with DV cases. This exploratory study represents research that begins to articulate the challenges and barriers faced by the child protection sector in addressing child risks in DV situations. Overall, child protection workers reported they were frequently engaging in risk assessment, risk management, and safety planning practices with clients. Participants were engaging in these practices at similarly high rates, suggesting that assessing risk and planning for safety is an integral component of their child protection work, especially given the reported high volume of exposure to DV referrals. Due to their unique position as receivers of mandatory reports, child protection workers viewed a critical part of their role as system navigators, in order to ensure victim caregivers were getting connected to necessary supports while providing information about legal system processes.

Workers indicated much of their assessment work was completed using the mandatory tools set out for all child protection investigations, with some adding they used their clinical judgment, based on training and experience with DV cases, to assess risk. The tools that participants discussed using were overwhelmingly ministry-standard tools for the child

protection sector. Few used additional structured risk assessment tools in their work outside of the mandated tools. Some workers were aware that the mandated tools were not specific to the risk of lethality in DV cases, and thus utilized DV lethality risk tools in high-risk cases. Further, many child protection workers were aware of the need to work separately with the victim and perpetrator to gather information regarding risk. This practice, based on recommendations from reviews with domestic violence death review committees and research with survivors of DV, is critical to interrupting the coercive control of the perpetrator and allowing the victim space to tell her story (Jenney et al., 2014; Ontario DVDRC 2018).

With respect to developing intervention plans once EDV had been identified, responses to the open-ended questions highlighted that workers were linking caregivers to appropriate services to mitigate risk. Interventions were focused on addressing the impact of the exposure to the children, the importance of which has been identified in previous research (Cross et al., 2012). Many participants discussed the collaborative and interactive nature of working with caregivers to assess and manage risk. The quality of this therapeutic alliance has been recognized as critical to ensuring safety (Dumbrill, 2006; Jenney et al., 2014). The key to forming and maintaining a good working relationship between child protection workers and clients is collaboration (Stanley, Miller & Richardson-Foster, 2012). The current study's participants emphasized the need to establish ongoing service plans to address risks with necessary safety parameters, while also respecting the autonomy of the primary caregiver. Child protection workers identified DV safety plans and interventions to be tailored to each family, rather than relying solely on structured safety planning tools, or a one-size-fits-all approach. Research has articulated the need for interventions that build on the ways in which non-abusive caregivers

protect their children and focus on engaging fathers to reduce the risk of exposure to DV (Jenney et al., 2014; Nixon, Bonnycastle & Ens, 2017)

Training, or the lack thereof, was a common theme expressed by child protection workers. Many participants identified a lack of training options available regarding DV and expressed a desire for specialized training. Indeed, the need for specialized training in the child protection sector has been identified in prior studies (Mills et al., 2000) and domestic violence death review committee reports (Ontario DVDRC, 2018).

Not all participants discussed the lack of training as an issue. Some participants received enhanced training on DV or DV lethality risk assessment tools which informed their work. Other participants identified they worked in specialized DV units along with receiving specialized training. Those participants articulated a more nuanced focus on developing safety plans that included engaging fathers and respecting the autonomy of the non-abusive caregiver. Researchers in the field advocate for training that addresses the complexities of DV and goes beyond the basic dynamics to include curricula on assessing protective and risk factors, the unintended consequences of achieving safety through separation, deeper understandings of why mothers remain with abusive partners, and the challenges in dealing with DV cases in the child welfare sector (Fleck-Henderson, 2000; Moles, 2008).

Resoundingly, support was expressed for the importance of working collaboratively with community partners to assess and manage risk. This finding has been reiterated throughout the literature and continues to be an area of focus in most promising practice guidelines (Healey, Connolly & Humphreys, 2018; Laing, Heward-Belle, & Toivonen, 2018).

Implications for Practice

Gathering and analyzing experiences from child protection workers provides insight into the realities of the complicated work that they face. This study demonstrated the complexities of working on the frontlines with families and the many different sectors that have the opportunity to intervene with families. A major theme identified in the current study, and emphasized in the literature, is the need for collaboration across sectors (Laing et al., 2018; Mills et al., 2000) Interfacing with professionals in other sectors (i.e., police, VAW sector, corrections) to assess risk provides the opportunity for each to share their knowledge and provide their perspectives on how to mitigate risk. While some workers described their successes with cross-sector collaboration, the process appears to vary across communities and is not without its challenges. Crucial to this collaboration is to establish policies and/or protocols with other sectors that outline respective roles in assessing and managing risk. While many child protection agencies have established protocols with police to identify risk, the specific processes vary across jurisdictions and may differ depending on the relationships between the sectors (Stanley & Humphreys, 2014). Having established policies and protocols based on a collaborative framework helps to facilitate more enduring partnerships to keep families safe (Healey et al., 2018).

Screening for EDV is mandatory for child protection screeners (i.e., those who take the initial report); however, how that screening question is asked and addressed can vary. Further, many workers commented on the lack of specialized training and highlighted the need for specific training on child risk for lethality or serious harm in cases of DV. Adequate training on the dynamics of DV and the impact on children can inform workers in performing skilled risk assessments. Managing high-risk cases with multiple risk and protective factors requires

specialized knowledge on the complexities of the intersections of many issues. Workers must be informed on not only the dynamics of DV but also the understanding of the risk factors for lethality.

While child protection tools do assess child safety within the context of DV, there is less of a focus on lethality risk or risk of severe harm in DV cases. These tools look at factors that are more global to child safety, when in fact more specific DV risk assessment tools may be quite useful in cases. Some workers do report using lethality risk or recidivism risk tools in high risk cases which points to the possibility of a two-step process that integrates both types of tools. It is standard to query for DV in every child protection referral, thus if it is found that DV is present, then child protection workers can use a more specific tool that addresses risk factors for lethality or severe harm in DV cases. Risk assessment tools are not an end-in-itself, however they provide a framework for the practice of determining the level of risk and informs planning for safety. More research is needed on the appropriateness of these tools in child welfare.

Future Research

More research focused on auditing service plans is needed to ascertain more specifics of the DV risk assessment process for participants. Surveys are inherently prone to response bias, and it is important to determine if child protection workers are doing what they are reporting.

Furthermore, there is a critical need to understand the service directions once DV risk is determined by child protection. With this, policies can be developed that direct interventions specifically and exclusively to the parent who is perpetrating the abuse. Differential response models in DV cases that have been implemented and studied in Ontario have found that interventions have often focused more broadly on referrals to services for family counselling and

improving parenting practices (Alaggia et al., 2013). These interventions need to be evaluated from a risk lens.

There is a growing body of literature centred around the idea of developing risk assessment tools based on the different typologies of DV as a means to inform type-specific interventions (Cavanaugh & Gelles, 2005; Lawson, 2019). Research is needed on the effectiveness of DV risk assessment tools in child protection cases. The availability of multiple risk assessment tools does not equate to the utility or effectiveness of these tools. It is important that the tools be evaluated for their effectiveness and helpfulness in the child welfare sector, particularly in determining the risk of harm to children and informing safety planning efforts.

Limitations

Although the current study yielded important findings, there are a number of limitations when considering the current research. For instance, the sample was not random and could have potentially led to the overrepresentation of workers who are well-versed in the area of domestic violence. Furthermore, our survey approach, with the option of open-ended questions, provided the opportunity to deepen the understanding of the quantitative data, but also, importantly, provided a rich understanding of child protection workers' experiences in their own words. Nevertheless, our research does not fully address the complexities of engaging with clients to develop service plans, the specific challenges faced by vulnerable populations, working collaboratively with other sectors, or the risk-related decision-making process involved. Similarly, the present study cannot tell us the actual 'effectiveness' of child protection system responses in terms of improving outcomes for those exposed to DV. Another limitation was that we asked participants the populations they engaged with overall, but did not look at different practices in different types of cases.

Conclusion

DV continues to be a significant social and public health concern that can have tragic consequences for victims and their children. The child protection sector is often at the centre of involvement when children are living with DV. Understanding the role they play in assessing risk and managing risk is important. This study sought to advance this understanding and determine what is working well and what improvements need to be made in assessing and intervening with victims of DV. Child protection services, along with police and violence against women agencies, are central to assessing risk for children, and together these agencies can work to manage perpetrator risk and help to keep children safe. Child protection workers have to be more prepared and specialized to work collaboratively to support victims and their children, and to hold perpetrators accountable to maintain safety.

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Chapter 4

Voices from the Frontline: Child Protection Workers' Perspectives on Barriers to Assessing Risk in Domestic Violence Cases

Abstract: Previous research has identified barriers for child protection workers in effectively intervening in domestic violence (DV) cases. The child protection sector has been criticized for placing the onus on victims to keep children safe and failing to engage perpetrators. This qualitative study examined barriers for child protection workers in assessing risk with families where DV is the primary concern. The sample included 29 key informants in the Ontario, Canada child protection sector who were interviewed on their risk assessment, risk management, and safety planning practices in the context of DV. The results indicated that key informants identified barriers at the systemic (i.e., lack of collaboration with community partners), organizational (i.e., lack of written policies or procedures specific to DV), and individual (i.e., client-worker challenges, high caseload, lack of ongoing training) levels. Specific difficulties in engaging and providing intervention for perpetrators were also identified. Finally, child protection workers highlighted a diverse range of promising practices in engaging effectively with victims, perpetrators, and their children. These findings emphasize the importance of community collaborations to manage risk with these cases, as well as ongoing consultation with DV specialists to respond and keep families safe.

4.1 Introduction

Living with domestic violence (DV) poses many risks of harm to children (Wathen & Macmillan, 2013; Wolfe, Crooks, Lee, McIntyre-Smith & Jaffe, 2003). Research on the adverse impact of childhood exposure to DV in the past two decades led to reforms in child welfare legislation that recognized it as a form of child maltreatment (Edleson, 2004; Fantuzzo et al., 1991; Wolfe et al., 2003). One of the most critical systems for addressing the needs of children exposed to DV is child protection (CPS). This study addresses the perspectives of CPS in Ontario, Canada as they relate to the challenges in assessing the risk that an abusive intimate partner poses to the safety and well-being of the child.

The role of CPS in exposure to DV (EDV) cases is to investigate reports and provide protective and preventive services when appropriate. Ontario has seen many legislative and policy reforms to address EDV. In 2000 the *Child Youth and Family Services Act* was amended to include EDV as a form of child maltreatment, which resulted in a 319% increase in referrals between 2000 and 2005 for children exposed to DV (Fallon et al., 2015). This change presented a challenge to CPS in terms of their response to this volume of cases. Coinciding with these reforms had been the implementation of child protection standards that emphasized risk (Jenney, Mishna, Alaggia & Scott, 2014). The current risk assessment tools utilized in child protection agencies, as outlined by the Ministry of Child and Youth Services, are not specific to the risk of lethality in cases of DV.

Largely as a result of recent recommendations from the Domestic Violence Death Review Committee in Ontario (DVDRC), changes to the *Ontario Child Welfare Eligibility Spectrum* in 2016 included a code (3.3.f.) that addresses the risk of dangerousness or lethality. This code is intended to identify cases that present with lethality risk factors, however, it is

unclear how CPWs are gathering information to assess this code. Despite revisions to the Child Protection Standards, with input from the violence against women sector and Office of the Chief Coroner, clear policies, protocols or guidelines for practice have not been widely implemented across agencies in Ontario. Across the province, and even within a particular child protection agency, there may be considerable disparity in the extent to which individual child protection workers assess and manage risk and safety plan effectively (Alaggia et al., 2015; Jenney, 2011).

Assessing Risk in Cases of EDV in Child Protection

There is extensive research on child protection practice and interventions with families experiencing DV (Hughes & Chau, 2013; Hulbert, 2008; Lapierre & Côté, 2011; Lavergne et al., 2011; Mills et al., 2000; Pennell, Rikard & Sanders-Rice, 2014; Postmus & Merritt, 2010; Shlonsky & Friend, 2007). Overall, there is a concern that child protection workers may not always accurately identify the presence of DV (Bourassa et al., 2006; Kohl, Barth, Hazen, & Landsverk, 2005; Rivers, Maze, Hannah & Lederman, 2007).

The child protection sector has been criticized for not providing guidance to workers on both the methods and timing of child welfare interventions in cases of EDV (Edleson, Gassman-Pines, & Hill, 2006). There are concerns that CPS holds mothers solely responsible for ending the violence (Douglas & Walsh, 2010; Alaggia, et al., 2015; Humphreys & Absler, 2011). Various factors may exist as obstacles to child protection workers effectively detecting DV in families, including parental denial, lack of evidence, heavy workloads of workers, lack of cooperation by parents, short duration of interventions, and parental substance abuse (Bourassa et al., 2006; Kohl et al., 2005). Irrespective of these problems, risk assessment is an important starting point that can be guided through the use of structured tools.

Assessment tools used in child protection. Research conducted within child protection systems suggests that screening and investigation of domestic violence are often insufficient (Hazen, Connelly, Kelleher, Landsverk & Barth, 2004). In Ontario, there are no standardized tools within child protection services that specifically assess for the risk of child lethality in the context of DV (Ontario Ministry of Children, Community & Social Services. (MCCSS), 2016). The MCCSS outlines child welfare risk assessment tools as per the Ontario Child Protection, which are not specific to lethality risks posed by DV (Jenney, 2011; Hughes & Chau, 2013).

The role within child protection of assessing risk in families where there is DV has been unclear (Jenney, 2011; Kohl et al., 2005; Postmus & Merritt, 2010; Radford et al., 2006; Shlonsky & Friend, 2007). Personal (e.g., demographic characteristics) and professional (e.g., prior case experience, agency policies and protocols) factors can influence a child protection worker's beliefs about DV and subsequently their response (Postmus & Merritt, 2010). One study of social service workers found that while child protection workers had more knowledge of DV than other workers, child protection workers had insufficient knowledge about communicating warning signs of perpetrator lethality and effective interventions with perpetrators (Button & Payne, 2009). Moreover, depending on how the level of risk to the child is conceptualized (i.e., directly or indirectly harmed, physically or emotionally), child protection workers may not remain involved with the family, thus missing the opportunity to address ongoing dynamic risk factors (Hughes & Chau, 2013).

Risk to children is closely connected to the safety of the non-offending parent (Cooley & Frazer, 2006). CPS has been criticized for being slow to realize that helping establish safety for the mother is synonymous with ensuring safety for the children in cases of DV (Hughes, Chau, & Poff, 2011; Shlonsky & Friend, 2007). Although there is a push for CPS practice to focus on the

perpetrator's behavior, a barrier in achieving this is the conflicting perspectives on how to best provide services to perpetrators (Healy & Bell, 2005; Lessard et al., 2010). CPS workers may find it difficult to engage effectively with perpetrating fathers (Jenney, 2011) as reflected in an Ontario study finding that only about one-third of perpetrating partners were successfully contacted or investigated (Alaggia et al., 2015).

Child Protection and Safety Planning

Risk assessment is designed to provide a basis for safety planning. Safety planning for children exposed to DV is utilized in both the DV and child protection sectors. In many jurisdictions, safety planning within child protection is a structured and mandatory response to a child protection referral (Fleck-Henderson, 2000). Within the DV sector, safety planning is often undertaken with the victim parent following a disclosure of DV. Victim safety planning may be conducted with victim service providers, either through police services or non-governmental services, including shelters, probation and parole officers, family services and family justice officials (Department of Justice Canada, 2013). Much of the literature suggests that effective safety planning includes both the mother and her children, along with cross-disciplinary collaboration that is guided by risk assessment (Kohl et al., 2005; Waugh & Bonner, 2002). Further, given DV interventions are not a 'one size fits all' prospect, there is a need to develop differential plans that respect victim autonomy but place children's safety at the forefront, with severity of violence and degree of coercive control tactics used guiding the safety measures taken (DeVoe & Smith, 2003; Jaffe, Crooks & Bala, 2009).

Within the child protection sector, safety planning for children living with DV requires knowledge of the dynamics of DV, and mobilizing a plan based on information gathered from assessing the level of risk. Jenney (2011) suggests that child protection workers should consider

differentiating DV cases from other forms of child maltreatment to expand the narrow view of what constitutes safety (i.e., leaving the abusive relationship) and incorporate more pragmatic solutions to improving the safety of women and children (i.e., engaging with men to end abusive behaviours). Critical to assessing risk and safety planning is the need to work collaboratively with other agencies.

The Importance of System Collaboration

Given that the presence of children often increases the number of agencies involved with a family, there is a need for inter-professional, cross-disciplinary collaboration in the risk assessment, risk management, and safety planning for children living in homes where there is DV (Hamilton et al., 2013). The importance of inter-professional, and cross-disciplinary collaboration is emphasized throughout the literature (Department of Justice Canada, 2013; Lessard et al., 2010; Mills et al., 2000; Murphy, 2010; Shlonsky & Friend, 2007; Stanley, Miller, Richardson Foster & Thomson, 2011; Turner et al., 2015).While the literature advocates for collaboration among professionals, there are barriers that need to be addressed to do this more effectively (Department of Justice Canada, 2013; Stanley & Humphreys, 2014). Issues in cross-sector collaboration often originate in concerns regarding information sharing and confidentiality (Kress, Adamson, Paylo, DeMarco & Bradley, 2012; Stanley & Humphreys, 2014). Policies and practices must be developed across sectors to address this issue in a manner that does not inhibit risk assessment efforts. One suggestion for achieving effective multi-agency risk assessments is to develop a common assessment tool to communicate risk across disciplines and with the client (Stanley & Humphreys, 2014). System responses to DV can be fragmented in part due to opposing interests and mandates (Jaffe, Campbell, Olszowy & Hamilton, 2014; Jaffe et al., 2015; Murphy, 2010; Turner et al., 2015).

Theoretical Framework: Exposure Reduction and Retaliation Effect

This study is focused on the critical role that child protection plays in responding to children living with DV. The research was guided by the Exposure Reduction and Retaliation Effect model (Dugan, Nagin & Rosenfeld, 1999, 2003), which posits that exposure reducing mechanisms (e.g., formal agency involvement like CPS and police) may, in fact, increase the risks of adult and child homicide. Dugan et al. (2003) theorizes that a high level of exposure reduction may generate strain within a relationship, whereby retaliatory violence occurs as a means to gain control back (Dugan, et al., 2003; Reckdenwald & Parker, 2010). In other words, if CPS and the police intervene without a proper risk assessment and management plan, it could make matters worse for the victim and children. Having a slight exposure reduction in severely violent relationships can be worse than the status-quo (Dugan et al., 2003). This point is especially relevant when children are in the home. An adult victim without children may find leaving an abusive relationship easier than an adult victim with children who become the subject of custody and access fights, as well as ongoing contact with the other parent. Several authors have highlighted the critical need for enhanced assessment of risk, victim safety, as well as risk management in responding to children living with DV (Dawson, 2017; Dugan et al., 2003). A response that is not commensurate with the ongoing risks a family faces will likely fail – the ultimate cost of this failure could be a homicide.

Current Study

There is limited research examining child protection workers' own perceptions on the challenges they face in providing an effective response to DV. The current study explored how child protection workers assess risk and the barriers they face in effectively assessing risk to inform safety planning efforts in cases where DV is identified. The current study was guided by

two overarching questions. Firstly, how do child protection workers understand and assess risk in DV cases and what do they think interferes with effectively doing this? Secondly, what are some promising practices that child protection workers use to help overcome these identified challenges?

4.2 Method

Overview

This study was a component of a Social Sciences and Humanities Research Council funded project, *Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations* (CDHPIVP; www.cdhpi.ca). The overarching goal of this national initiative is to enhance cross-sector collaboration and identify the unique needs and risk factors that can heighten exposure to violence for vulnerable populations, including Indigenous, rural, remote and Northern communities, children living with domestic violence, and immigrant and refugees populations. The CDHPIVP focused on seeking to understand barriers to effective risk assessment, risk management, and safety planning, as well as promising practices in enhancing collaboration among services and preventing domestic homicides. The current study utilized data from phase two of the project, which focused on interviewing key informants working in various sectors to gain a deeper understanding of current practices in risk assessment, management as well as safety planning.

The current study consisted of interviews with professionals in the child protection sector in Ontario, Canada. The participants differed in their level of experience in the field, their roles at their respective agencies, and the degree to which they worked directly with clients as part of their role.

Procedure

Ethics approval was obtained from the research ethics review boards at the CDHPIVP's lead universities, Western University and the University of Guelph, before data collection. Professionals working in the area of domestic violence were initially contacted to complete an online survey which asked questions about their risk assessment, risk management, and safety planning practices, as well as their work with identified vulnerable populations. Participants who completed the survey and expressed an interest in participating in a more detailed phone interview were contacted (n = 36; 27.7%). Of those who expressed initial interest to complete an interview, approximately 64% (n = 23) consented and participated in the interview. Additional participants (n = 6) were recruited through the networks of the CDHPIVP as well as the use of a snowball sampling technique.

Interviews. The interviews with key informants were conducted between 2017 and 2018 by graduate student research assistants. The interviews ranged from approximately 45 to 60 minutes and were conducted in a quiet location. Prior to starting, the interviewer obtained consent from participants and explained the purpose and questions in the interview. The interview questions focused on the key informants' roles at their respective agencies, their experiences with risk assessment, risk management, and safety planning practices, and the challenges, risks, and promising practices associated with working with vulnerable populations. Probes were utilized as part of the interview protocol to elicit further responses to certain questions (e.g., "Can you elaborate further on that?"). Permission to audio record was granted for all of the interviews that were used for this research study. No identifying information was used in the interview and audio recordings were transferred onto an encrypted computer in a locked room. All communications with project coordinators and any data transfers were made through

the use of a secure email software. The interviews were transcribed verbatim by research assistants and re-checked for accuracy by the original interviewer.

Data Analysis

Using a thematic analysis, I analyzed the interviews with both a deductive and inductive approach at the semantic level (Braun & Clarke, 2006). This approach allowed me to continue to draw from an established theoretical base while being flexible in the interpretation of the data (Joffe, 2012). Thematic analysis emerged through a multi-phase process which included reading and rereading of interview transcripts, field notes, and the research literature (Edmunds et al., 2011). A provisional codebook was developed from preliminary analyses of the content of the interviews, which was then presented and discussed within a group of graduate students and a principal investigator for the CDHPIVP. This initial process provided space for analytical exploration of evolving themes as well as the overall relevance and specificity of codes (Saldaña, 2011). Memos and notes were made and used for points of clarification and journaling of additional information throughout the coding process.

A trial sample of transcripts was coded by three senior graduate students using the provisional codebook to determine the suitability and ensure credibility. After the trial transcripts were coded, deliberations occurred on the suitability of codes, related definitions, other emerging themes, as well as any discrepancies between coders. Once updated, the first cycle coding utilized broad descriptive coding, and more refined sub-coding, as well as simultaneous coding to categorize the interview data. The resulting codebook was utilized to code all de-identified transcripts using a qualitative software program, Dedoose (V.8.1.8). Consultations continued through the coding process with other qualitative researchers to ensure that the procedures, results, as well as interpretations of interview data, were representative and appropriate.

Participants

Interviews were conducted with a total of 29 participants working in the child protection sector in Ontario from 19 different child welfare agencies (see Table 4.1).

Table 6. *Characteristics of Interview Participants* (*N* = 29)

	n	%
Role Type		
Supervisor/Manager	12	41.4
Intake	2	16.7
Ongoing Services	10	83.3
Frontline	17	58.6
Intake	4	23.5
Intake and Ongoing CPW	1	5.9
Ongoing CPW	11	64.7
Domestic Violence Worker	1	5.9
Years' Experience		
<3 years	2	6.9
3-5 years	2	6.9
6-10	9	31.0
11-20	11	37.9
20+	4	13.8
Unknown	1	3.5
Location of Agency (MCCSS regions)		
North	3	10.3
East	2	6.9
Central/Toronto	6	20.7
West	18	62.1

4.3 Results

Several themes and subthemes emerged when examining CPWs perspectives on the challenges and barriers to assessing risk in DV cases. The themes were related to the issues that CPWs face at a systemic, organizational (i.e., within the child welfare agency), and individual level (i.e., specific to CPWs and clients), along with challenges that underscored all levels (see Figure 4.1).

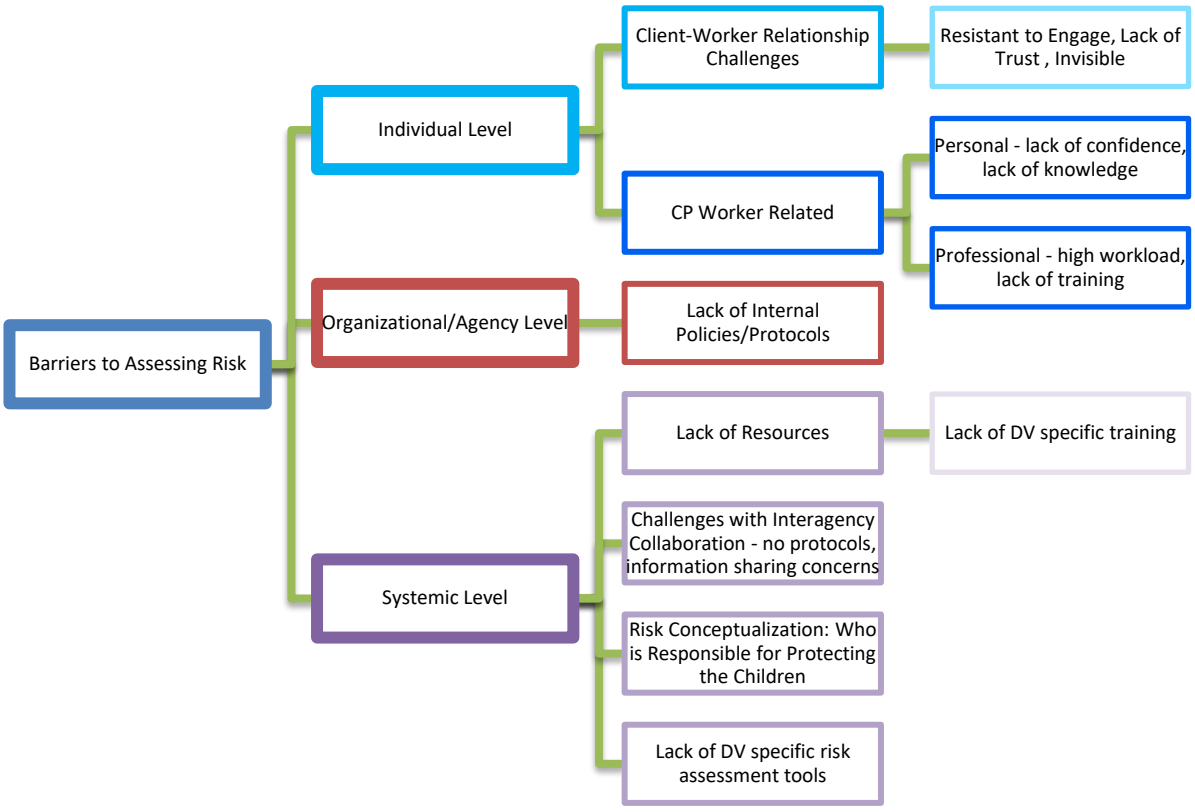

Figure 3. Barriers to Risk Assessment

Individual-level barriers

Participants frequently discussed barriers at the individual level, both interpersonally with clients and intrapersonally, that made it challenging to assess risk.

Client-worker relationship challenges. Many workers talked about the challenge in engaging with victims or perpetrators due to a lack of trust with child welfare professionals:

> *"We do have some families where there is domestic violence and neither parent wants to cooperate because CAS has that stigma. We're slowly starting to see that stigma change, where our role is to go into the home to keep the family together, but I mean if there is imminent high risk, we don't have a choice. It's our very last resort to remove children from their home."* (Worker # 3)

Another participant described the dilemma of managing working relationships with both parents:

> *"Now, technically, the way child protection is set up, the onus sometimes gets placed more on the victim to protect her children, as opposed to the perpetrator, because typically he doesn't want to work with us on a voluntary basis, but the victim generally does. So, it becomes a little unbalanced, unless we do end up going to court and starting a child and family service application.*" (Worker # 9)

One participant articulated the dilemma of working with the victim parent when there is a difference in how the non-offending parent and the CPW see the risk to children:

> *"Sometimes the victim's view of risk is much different than what the risk factors tell us and what our professional judgement tells us and may be the fact that we are privy to more information. For instance, the perpetrator has offended against other victims that the current victim isn't aware of. So, there may be more information that we know of to use in the risk assessment that even the VAW is not aware of or police are aware of."* (Worker # 14)

The difficulty engaging and working with the perpetrating parent was identified as an area that participants acknowledged child welfare has not been *"consistent at or necessarily good at."* Some participants reflected on the purpose of intervening with perpetrating fathers and the struggle to know how to engage them in addressing their risk:

> *"…the engagement process for these guys is to have the conversation about their lives and about what are their worries and how do they see themselves as a father and what they want for their kids and what they want for their exes and those kinds of pieces. I think we don't do that because we get really focused on, 'tell me about the charges, tell me what happened on February 14th,' kind of that stuff and then it shuts guys out."* (Worker # 25)

Worker challenges. Further, participants pointed to individual worker intrapersonal barriers, such as recognizing the impact of workload on the quality of the risk assessment process, as one participant suggested:

> *"Workers will just complete the risk assessment online because it's just part of the software system just so that they can check that box off that they have done that as opposed to engage the family because they have way too many files and too much going on."*

There were also concerns expressed about the impact of interviewing a perpetrating parent who they feared may pose a risk to their own personal safety:

> *"…if you're talking about a gentleman who is quite misogynistic and really hates women and has no qualms with hurting people. I mean 90% of us CAS workers are women. Some of them young. We've got to keep them safe too."* (Worker # 11)

One of the questions posed to participants was whether or not they used professional judgement in their assessment of risk. Most of the participants described relying on their experience and professional training in their assessment of risk. Some indicated that they would use professional judgement when the specific incident they were investigating was not serious, but the file history suggested a pattern of concerns. In these cases, they would use their professional judgement to determine their intervention.

Several workers identified concerns with respect to their own skills and competence in assessing risk with DV cases.

> *"Best practices are out there-- there's lots of research and lots of knowledge and assessments and things that you can use, but how do you make it so that it's ingrained in your practice and not sitting on shelf somewhere collecting dust?"* (Worker #26)

Organizational-level barriers

Participants identified challenges they experienced related to the internal practices of the child welfare agency where they were employed. Many discussed the legislation and their mandate and role in assessing risk to children. However, participants acknowledged the gaps in translating the child welfare legislation/child protection standards into their practice on the frontline. They often commented on the absence of specific agency policies/protocols for the assessment of risk in DV cases. Within organizations, there is also a recognition that the inconsistency of child protection workers response can be a barrier to assessing risk in DV cases.

Even when the policies and DV risk assessment tools are available to guide workers, some do not use them consistently. Participants opined:

> *"You know obviously, each worker has their own independent DV assessment and what violence looks like in a relationship. I guess screening is very individualized in that sense."* (Worker # 15)

> *"Risk assessment is tailor-made to the worker and the work that they are doing with families... Obviously, if there is an issue such as repeated violence…we need to address things and deal with them, but the way that they are dealt with is very different depending on what worker you are assigned."*(Worker # 22)

System-level barriers

Risk conceptualization. Participants discussed that a significant challenge for child protection workers in cases of DV is the result of "a flaw of the system" related to the conceptualization of who poses the child protection risk and therefore, who should be the focus of child protection interventions and risk management plans. It was suggested by participants that child protection workers tended to engage the victim parent, which is most often the mother, rather than the parent who is posing the risk to the children. As one participant describes below:

> *"Our recording system and even just the practices of agencies is to identify the primary caregiver as 99% of the time, the mother. And in doing so, the risk assessment is then constructed around her, and so the secondary partner really doesn't fit."* (Worker # 29)

One participant suggested the child protection system places victim mothers in a bind by requiring them to take actions that may have unintended consequences:

> *"Women who are expected to 'act protectively' and withhold the access, but nobody ever sits down and says to him, 'how are you going to keep your kids safe?" And that's fair criticism because it's not something we've historically done well and even now we are still really not great at."* (Worker # 25)

Finally, another participant identified how the existing tools and language used (i.e., DV noted as "conflict") within the child protection and family law system does not adequately address the nature of domestic violence and how the process can be stigmatizing for victim mothers:

> *"In family court, if we file a protection application, it is really neutralizing the violence because we are finding the children in need of protection from both parents and both parents are held responsible to protect the children."* (Worker # 11)

Challenges with inter-agency collaboration. Many participants commented on difficulties they had in working together with police and other service providers with respect to sharing information and engaging in collaborative practices that aid in assessing risk. There were also concerns that some service providers were not clear on distinguishing the difference between sharing information and their duty to report. One participant described these barriers within their community:

> *"Lots of times we are not being notified because the child was not present. Just because the child wasn't present for the assault, but there is still a child that lives in that home, there is still a role for us."* (Worker # 8)

Some participants expressed frustration collaborating as outlined in inter-agency protocols:

> *"If the mother has disclosed that there is domestic violence, we are obligated to investigate that and we would work with police on how to address that, but at the end of the day, the police are going to do what they want to do. I feel like they are not always following the procedure that we developed for them ten years ago."*(Worker #4)

Another participant felt that inter-agency collaboration around risk assessment can be confusing since child protection utilizes a standard risk assessment tool which is not specific to DV risk:

> *"We have our own risk assessment tools we use in child protection and sometimes we have some troubles with our VAW sector colleagues in terms of what risk assessment we're using."* (Worker # 11)

Cross-cutting themes

Lack of DV specific tools. Many participants discussed the lack of tools used specifically for assessing risk of harm or lethality in DV cases. While they have several mandated tools, those tools examine a wide range of risk factors for child maltreatment, with exposure to partner conflict being only one factor. One participant summed up the dilemma as:

> *"I think the difficulty for us is that we have our own risk assessment in child welfare. Our risk assessment is broader to look at risk in general as opposed to really using risk assessment to understand the level of risk for those experiencing domestic violence. […] our existing risk assessment quite frankly does a very poor job on assessing the risk of domestic violence."* (Worker # 29)

Another participant reflected the concern about assessing child lethality risk in DV cases:

> *"I think the challenge for us in terms of an agency … there isn't a risk assessment per se that assesses the risk to children, so we kind of have to go with the theory that if a mother is at risk, if the parent is at risk, then the child is at risk".*

Many commented on the insufficiency of specific risk assessment tools for DV lethality risk:

> *"The only thing that is specific to domestic violence in that assessment is whether there has been partner or adult conflict in the family in the past year. So, it is no or yes, those are the only two options. You can't write in anything additional, and it doesn't speak to the severity of the conflict. I do feel like the tool needs to be updated."* (Worker #7)

Lack of DV specific training. Many participants spoke about the lack of specific training related to risk assessment in DV cases. They also described that specific training usually does not occur in the new hires training materials, so newer staff must rely on supervisor direction or peer mentorship when assessing risk in DV cases. Participants reported:

> *"We don't have a system in place to make sure that everybody has training as they come in so sometimes there will be a time lag before they have any formal domestic violence training."* (Worker # 13)

> *"Once you get hired, you get to go out with other people and learn how to use the system, and then you start getting files before that initial training. It is a very challenging situation, and I think that was resulting in a lot of burnout for workers."* (Worker #15)

Promising Practices

Throughout the interviews, many participants discussed the ways in which they overcame the challenges and barriers they faced. These promising practices related to the working relationships between service sectors involved with the family.

Collaboration. The importance of cross-sector collaboration was emphasized by many participants. Several participants commented on how they overcame challenges to work together with other professionals in the field to support safety in families. Several participants were working in communities that operated co-located services. One worker commented specifically on how their agency has worked with the Violence Against Women (VAW) sector to fill the gaps in the child protection system in terms of assessing and addressing risk for families:

> *"That's where we go back to risk assessment - because the shelter folks do the actual DV risk assessment. We have a risk assessment, but it is for future maltreatment for children so that encompasses a lot of things and not specific to DV. Our shelter worker always gets a copy of that which is unheard of back in the day. We would not have been privileged to that."* (Worker # 21)

Building trusting relationships. Participants discussed the importance of collaborations in building trusting relationships within the DV professional community.

> *"I have developed relationships with probation officers where we work on safety; police as well, where we have trusting relationships that facilitate work both formally and informally, shelter staff where I have good relationships and participate in risk assessment and safety planning jointly and informally; often times with the Band where information can be shared informally about a family member and building trusting relationships there that are so important; with the schools on the reserve and building trusting relationships there as well."* (Worker #23)

Protocols. It was clear that having protocols in place with service providers in the justice, social service, and the health care systems was helpful for CPWs when intervening with DV. Participants identified that clear policies outlining the opportunities for collaboration between

police, VAW sector, corrections, legal, mental health and health care sectors addressed challenges with information sharing and confidentiality. It was clear that participants perceived the presence of policies and protocols to be instrumental in preventing tragedies:

> *"That is probably why we have such a low number of fatalities or homicides compared to elsewhere because we have a good service, and we have local protocols where we are allowed to talk to each other and help out a family or a woman, and then you got a whole neighbourhood that won't hesitate to call."* (Worker # 13)

Training. Workers commented on the value of enhanced training in the area of DV that informed their work. This training often occurred with other sectors to provide further opportunities to build relationships and understand how they can work together to assess risk. Some child protection workers received training on specific risk assessment tools, such as the Danger Assessment, ODARA, or B-SAFER, whereas others received more authorized worker training through the Ontario Association of Children's Aid Societies on the impact of child exposure to DV and the intersections of woman abuse and child maltreatment.

Competent clinical supervision. Many frontline workers and supervisors talked about the importance of reviewing cases with their direct supervisor. One supervisor of an ongoing services team highlighted the process:

> *"When we start to get concerned about some of the risk factors that indicate higher risk that's when we will use a checklist of about 39 high risk factors that we will go through with women. Not all workers will think of that on their own, so that's sometimes a discussion, and I'm aware of it with my staff."* (Worker #6)

Paradigm shift in the child protection response to DV risk. While there were concerns expressed about the tendency for child protection workers to impose a safety plan on victim parents, there was also a strong endorsement for a shift in the paradigm for child protection in their interventions with DV victim parents. Some of these shifts included:

> *"We're moving away from that telling people what to do, to identifying this is what we're concerned about what do you want to do about it?"* (Worker # 27)

> *"You know the minute we begin to hold men accountable and shift the language, then I believe we will see a shift in our practice."* (Worker # 25)

4.4 Discussion

The current study focused on interviews with 29 child protection workers across Ontario and examined their experiences with assessing risk in DV cases in the context of current standards of practice in the province. Participants identified barriers at the systemic, organizational and individual levels that made assessing risk in DV cases quite challenging. Conversely, participants identified some collaborative approaches that seemed to increase cross-system dialogue and improved practice. Historically, the role of CPS in DV cases has not been viewed as therapeutic and has been seen to be oppressive to mothers' autonomy. Child protection workers experience challenges when assessing risk and child safety in cases involving DV. They are mandated to ensure child safety while also supporting the integrity of the family and enhancing child well-being. Often, when DV is identified, service providers are challenged with how to engage the perpetrator in acknowledging and managing their risk. When the perpetrator is also a father, child protection workers are in the unique position to hold them accountable. This authority, when used therapeutically, can help ensure safety in the family where there might otherwise be resistance or reluctance to engage.

Risk assessment processes and lack of DV lethality risk specific tools. Many child protection workers discussed that while there are numerous provincial ministry standards and risk assessment tools embedded in child protection practice, those tools are not specific to the lethality risks posed in DV cases. While there was agreement that using specific lethality risk

assessment tools is important, many indicated that their own agency did not have procedures requiring them to do so. The use of specific DV lethality risk assessment tools was arbitrary and based on the practice decisions of individuals or groups within agencies, such as specialized units.

Adequately assessing risk requires the child protection worker to gather information that is accurate and fulsome. For some mothers, discussing specific dynamics in the family brings with it the fear that child protection interventions will be imposed on them (Devoe & Smith, 2008; Shlonsky & Friend, 2007). In some circumstances, the CPW's authority can be perceived by the mother as coercively controlling, and mirror the dynamics experienced in the intimate partner relationship, thereby inhibiting her willingness to provide information about risk. For the child protection worker, the focus is on the children as victims, and while there is often a desire to form a cooperative working relationship with the mother, it is often secondary to ensuring actions are taken to protect the children. The consequences of failing to effectively identify risk can be fatal to children. Previous research on domestic homicides has highlighted that the presence of common risk factors indicated the increased likelihood for lethal violence in an intimate partnership (Campbell et al., 2003; Dawson, 2017, Ontario DVDRC, 2018). The Ontario Domestic Violence Death Review Committee has found that 71% of all the cases reviewed had seven or more known risk factors present prior to homicides occurring (Ontario DVDRC, 2018).

Risk conceptualization and engaging fathers. Many participants indeed noted the flawed system of which the status quo was to work mainly with the protective parent. A major challenge that workers expressed was the need to do a better job of working with and addressing perpetrator behaviours. While many workers understood the importance of holding men

accountable, the terms in the plans of service usually addressed the actions the mothers must take and not necessarily what the father was required to do. These barriers of the system were reinforced by practices such as opening the file under the mother's name, even if the reason for service was the child's exposure to violence perpetrated by the father. Workers at the frontline can only do so much within the confines of their role to combat this inherent systemic bias of seeing mothers as being mainly responsible for the protection of their children (Brown, Callahan, Strega, Wallmsley & Dominelli, 2009).

With current practices, workers can typically comply with case standards by meeting with the mother and the children, without the expectation that they must meet with the battering father (Mandel, 2010). To facilitate child protection procedures that address DV perpetrators behaviours, there is a need to increase child protection workers' knowledge about how best to address these abusive behaviours (Healy & Bell, 2005; Maxwell). Similarly, CPWs also require the skills and willingness to engage with the perpetrators of DV in a change process to ensure the child and mother's safety (Jenney, 2011). Previous research on CPWs own perspectives of their services has identified a lack of training being provided that specifically examines managing DV perpetrators behaviours (Jenney, 2011; Stanley et al., 2012). Furthermore, CPWs have expressed difficulties with working with perpetrators of DV and comment on the limited resources at their disposal (Lapierre & Côté, 2011). While the child protection sector has made significant improvements in working with victims of DV, the current study indicated that CPWs need continued training, supervision and support aimed at increasing skills and confidence in working with perpetrators of DV (Stanley & Humphreys, 2014). For the most part, participants from the current study endorsed the notion for holding men accountable and developing better strategies for engaging fathers. The findings articulated the importance of considering a paradigm shift for

the child protection sector of holding fathers accountable for their risk by developing service plans that focus interventions on them as opposed to the mother. Such a shift would include routinely opening files under the father's name when the reason for the investigation is his violence in the family. These practices are aligned with the exposure reduction and retaliation theories, as reducing exposure and managing risk of perpetrators is necessary to reduce the risk of lethality. When services do not respond effectively to the risk raised by the perpetrator, the victim ends up in even greater danger after disclosure of DV.

Implications

The current study provides a number of implications for practice in the child welfare sector, as outlined below.

Standardizing best practices for assessing risk in DV cases. It was apparent that many of the participants were knowledgeable about the dynamics in DV cases and the inherent risks to children living with DV. However, it appears that there continues to be a need to standardize risk assessment practices with DV cases and anchor them with specific lethality risk assessment tools. There was a wide range of views on child protection best practices related to DV cases, and while DV is addressed in some of the tools and practice standards (Ontario Eligibility Spectrum and the Ministry Child Protection Standards), risk assessment procedures and tools are not specific to the risk of lethality. The current study highlighted that even though all agencies receive funding from the same ministry, there was considerable variability with the actual practices of workers on the frontline. Although consistency is difficult, an adequate assessment of risk is critical to preventing tragedies and saving lives. Child protection workers operate from the policies and protocols that are in place within their agency, and dependent on what the

agency facilitates in terms of ensuring they receive enhanced training and take part in collaborative efforts.

Training. Training is a critical first step to increasing knowledge and skills and becoming a competent worker (Button & Payne, 2009). As indicated in previous studies, child protection workers need to recognize the complexity of risk assessment and safety planning, and to use that knowledge as a means of working with DV cases more collaboratively (Jenney, 2011; Murphy, 2010; Stanley & Humphreys, 2014). Workers revealed a lack of training specific to DV, initially and on an ongoing basis. Findings from the study indicated that it would be important to ensure that specialized training in DV lethality risk assessment and risk management is available, and that such training is sequenced, so that CPWs receive this training early in their career. One exemplary training model on working with DV cases in the child welfare sector is the *Safe and Together Institute* (https://safeandtogetherinstitute.com). This institute delivers child welfare DV training, which provides a framework for partnering with victims and intervening with perpetrators to enhance child safety and well-being. The training provides tools and interventions that support sustainability and integration with local initiatives, mandates and resources.

Collaboration. Cross-sector collaboration is critical to ensuring information sharing is comprehensive and communicated to address safety concerns. These collaborations are improved when stakeholders use common frameworks, tools, and language (Humphreys, Healey & Mandel, 2018). One option for promoting effective multi-agency risk assessments is developing a common assessment tool to utilize to communicate risk across disciplines and with the client (Stanley & Humphreys, 2014). Protocols must be developed between sectors to address this issue and in a manner that does not inhibit risk assessment efforts. One promising practice identified in the literature and endorsed by participants is the utilization of high-risk case coordination

protocols, whereby justice partners and other professionals from multiple sectors meet to discuss individuals identified as high risk, to coordinate risk management strategies (Department of Justice Canada, 2013). This type of case planning can focus on the safety and well-being of all victims within the family. Another avenue to collaboration is through co-location. A co-located model, such as a family justice centre collaborative model (Gwinn, Strack, Adams & Lovelace, 2007), is one exemplary model of collaboration whereby multiple service providers dealing with DV cases work together under one roof.

Limitations

Several limitations emerged in the current study. The sample was drawn from the child welfare sector in Ontario. Child protection mandates in Canada are determined provincially, and as such, each province has its own legislation, standards, and tools. The findings of the current study may not be applicable or generalizable across Canada and other jurisdictions without a proper analysis of specific standards and legislation related to DV within the child protection mandate. However, drawing from a sample in one province allowed for less complexity when factoring in legislative mandates, standards of practice, and regional differences. It is also important to acknowledge that participants in the study were a self-selected sample of key informants, which is inherently biased. The workers volunteering to be interviewed may have had a greater degree of confidence and knowledge regarding the subject matter and may not be representative of the average Ontario child protection worker. Nonetheless, the interviews provided a variety of knowledge and experience offered by the child protection workers and a clear concern about gaps in service and training in child protection services.

Although many consistent themes were apparent in the qualitative analysis, the sample size did not allow for additional analyses, such as a comparison of more experienced workers

with less experienced workers or those CPWs in mainly urban centres versus rural communities. The study did not address regional differences in working with vulnerable populations. Some CPWs would be working with more vulnerable victims, such as Indigenous women with a history of colonization and oppression as a major context in examining DV and the CPS response. There is a history of distrust in Indigenous communities towards CPS based on the "sixties scoop" when Indigenous children were removed from their families and put in foster homes or adopted away from their cultural roots and language (Truth and Reconciliation Commission of Canada, 2015). Indigenous children are overrepresented in many child welfare agency jurisdictions in Ontario (Ontario Human Rights Commission, 2018). Other CPWs may be in larger urban centres, which would face a larger influx of immigrant and refugee families and complex challenges specific to these diverse communities. Another limitation which several key informants raised is the concept of promising practices. Although these practices were innovative, there was no evaluation of their effectiveness within this study.

Future Research

Many of the limitations discussed above could be addressed in future research. Although this study provided a good overview of issues for CPS addressing domestic violence in Ontario, it would be important to examine patterns in other provinces and territories in the context of different legislations and resources. Even within Ontario, there would be regional differences to explore based on urban versus rural and/or northern counties, which would have less resources and greater challenges serving families. In particular it would be important to gain the perspectives of CPW serving Indigenous communities and the barriers to developing trusting relationships with families living with domestic violence. Future research could also examine the

culturally diverse communities being served in urban centres and some of the unique obstacles intervening in immigrant and refugee families.

Future research can also focus on the effectiveness of risk assessment tools that support the role of CPS and the clear need to collaborate with different systems in providing safety planning and risk management strategies. Collaboration is central to protecting children, and evaluating the work of the overall community response may be as important as the work of any individual agency. Key informants in this study offered many promising practices. However, research needs to be undertaken to see if promising translates into effective for children living with domestic violence. Consistent with the risk reduction and retaliation theories, it would be important to see if the interventions offered greater risks or enhanced safety for adult victims and children.

Conclusion

Child protection workers play a critical role in ensuring child safety in families where DV has been reported. While child risk assessment tools for child protection are standardized, it is recognized that they are not specific to the risk of lethality in DV cases. This study reported on the findings of qualitative interviews with child protection workers and supervisors to elicit their views on risk assessment practices with DV cases within the child protection sector. Child protection staff identified the need for agency policies that endorse the use of specialized DV lethality risk assessment tools. There was an acknowledgement of the tendency for child protection workers to direct their service plans on the mother, and an awareness of the need to engage fathers in addressing their risk. As well, enhancing collaborative cross-sector practices that support front line worker interventions within the CAS/VAW sectors was emphasized. Participants identified promising practices in this area, including co-location models, and safety

planning conferences that include formal (professionals) and informal supports (woman and individual in her life who can support her). Training was identified as an area needing focus, specifically as it pertains to prioritizing enhanced DV risk assessment training that would be available at the outset of employment for child protection workers.

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Chapter 5

Final Considerations

This dissertation focused on the critical role of child protection in responding to domestic violence and recognizing the potential risk of adult and child homicides. A series of connected studies were undertaken to examine both the depths of the risks for families dealing with domestic violence, and child protection workers' views on how to enhance current efforts in the field.

5.1 Overall Findings

Taken together, the three studies provide insights into the significant warning signs present prior to domestic and child homicides, as well as perspectives from frontline workers and supervisors in the Ontario child protection sector. Domestic homicides often appear predictable and preventable with hindsight because of the number of known warning signs associated with these tragedies. Through the lens of the exposure reduction theory and retaliation/backlash hypothesis (Dugan et al., 2003), the need for the child protection sector to recognize the difficult circumstances of women and children living with domestic violence is emphasized and calls for a nuanced understanding of children's risk in these circumstances. No one agency or sector can do this alone. The response requires prevention efforts through an ecological framework that coordinates community efforts from multiple sectors at the individual, family, community, and societal level (Heise, 1998). This research sought to further understand and explore what is working well and what improvements need to be made to the child protection system response to DV.

Learning from study one. In chapter two, results were presented from research examining the involvement of child protection services (CPS) prior to domestic homicide cases

reviewed by a domestic violence death review committee in Ontario. More than one in five of the homicide cases where children were present in the family system had prior involvement with CPS. CPS involvement did not differ in cases where children were killed compared to cases where children were present but not killed. The cases that CPS was involved with had significantly more total risk factors and the family was involved with significantly more agencies. Lastly, DVDRC recommendations directed to the child welfare sector indicated the need for enhanced screening for DV, specialized DV training, increased cross-sector collaboration, enhanced ongoing service provision to promote child and victim safety and to hold perpetrators accountable, and amendments to internal policies/protocols following a DV-related death in child welfare populations.

The outcomes in the analyzed cases reflect missed opportunities to focus on risk assessment and to utilize the information gleaned to inform risk management and safety planning efforts. Findings emphasized the need for continued efforts to engage communities to develop awareness and increase cross-sector collaborations to assess and manage risk. This study highlighted the need to further understand how to enhance the CP role in DV cases.

Learning from study two. In chapter three, findings were presented from an online survey of 138 child protection workers in Ontario on their risk assessment and safety planning practices with DV cases. Assessing and managing risk was frequently and consistently completed across the province, however the specific strategies and identified challenges varied. Workers indicated much of their assessment work was completed using the mandatory tools set out for all child protection investigations with some adding that they used their own clinical judgment, based on training and experience with DV cases, to assess risk. Some workers reported using other standardized risk assessment tools (i.e., Danger Assessment, B-SAFER) to

complement their own measurement of risk and planning for safety in higher-risk cases. Emphasis was placed on consistently working collaboratively with families and professionals in other sectors to address risk. This practice, based on recommendations from reviews with domestic violence death review committees, and research with survivors of DV, is critical to interrupting the coercive control of the perpetrator and allowing the victim space to tell her story (Humphreys, Healey & Mandel, 2018; Jenney et al., 2014; Ontario DVDRC, 2018).

Learning from study three. In chapter four, 29 Ontario child protection workers provided their in-depth perspectives on assessing risk with families where domestic violence is the primary concern. These key informants identified a number of barriers at the systemic (i.e., challenges with collaboration with community partners), organizational (i.e., lack of written policies or procedures specific to DV, inconsistency in practice), and individual (i.e., worker-client relationship barriers, high caseload, lack of ongoing training) levels. Specific difficulties in engaging perpetrators were also identified as significant challenges for child protection workers. Encouragingly, some service providers identified a diverse range of promising practices in overcoming barriers and engaging successfully with victims and perpetrators.

Overall, the three studies highlight the critical role that child protection services can play in potentially saving lives lost to domestic homicide. Child protection workers are involved in high risk and complex cases that require the best possible risk assessment and intervention. Child protection can do a better job with the referrals they receive regarding child exposure to domestic violence. However, they cannot make changes alone. Child protection requires enhanced community collaboration to address domestic violence that is headed on a path to homicide. The present research findings stress the importance of multi-disciplinary collaborations, and specialized ongoing training in engaging perpetrators and managing risk. There is a need for

further research to evaluate the effectiveness of child protection's best efforts to address domestic violence in the lives of children.

5.2 Future Directions

This section covers two aspects of future directions arising from the research presented in this dissertation: implications for practice and areas for future research.

Implications for Practice

> *"Best practices are out there-- there's lots of research and lots of knowledge and assessments and things that you can use, but how do you make it so that it's ingrained in your practice and not sitting on shelf somewhere collecting dust?"* (Participant from study three)

The words of a key informant above frame the challenge and the hope in the field. The purpose of this dissertation was to deepen the understanding of the potential role of the child protection sector in preventing domestic homicides. By examining child protection workers' perspectives on assessing risk in cases where DV is a primary concern, insights were gained into the existing barriers they face as well as the strategies that represent promising practices. This research reiterated that the child protection setting is a particularly challenging practice context, as workers have to balance demonstrating empathy and responsivity to parental needs with their protection mandate to assess child risk and intervene when necessary (Hughes, Chau & Vokkri, 2013). There is a need for interventions that build on the ways in which non-abusive caregivers protect their children and focus on engaging fathers to reduce the risk of exposure to DV (Jenney et al., 2014; Nixon, Bonnycastle & Ens, 2017; Scott, Thompson-Walsh & Nsiri, 2018). The current study emphasized that efforts to improve the child protection response need to be viewed through an ecological framework that addresses multiple factors/issues at the individual worker, agency, and community and policy level.

Internal Changes to Risk Assessment Processes in EDV Cases

Adequately assessing risk requires that the child protection worker can gather information that is accurate and fulsome. All three studies identified the need to increase measures to properly assess all parties involved with DV and not just focus on the adult victim. It was recognized that the use of authority within child protection can mirror the coercive control dynamics experienced in the relationship, or be seen as paternalistic behaviour, and therefore inhibit the mother's willingness to provide information about risk (Mandel, 2010). For the child protection worker, the focus is on the children as victims, and while there is often a desire to form a cooperative working relationship with the mother, it is often secondary to ensuring actions are taken to protect the children.

It was apparent that many of the participants were knowledgeable about the dynamics in DV cases and the inherent risks to children living with DV. However, it appears that there continues to be a need to standardize risk assessment practices with DV cases, and anchor them with specific lethality risk assessment tools. There was a wide range of views on the child protection best practices related to DV cases, and while DV is addressed in some of the tools and practice standards (Ontario Eligibility Spectrum and the Ministry Child Protection Standards), risk assessment procedures and tools are not specific to the risk of lethality. The current study highlighted considerable variability in practices of frontline workers. Child protection workers operate from the policies and protocols that are in place within their agency; these are dependent on what the agency facilitates in terms of ensuring workers receive enhanced training and take part in collaborative efforts.

Risk conceptualization and engaging fathers. The findings articulated the importance of considering a paradigm shift for the child protection sector of holding fathers accountable for their risk. A major challenge identified across all three studies was the need to do a better job of working with and addressing perpetrator behaviours. While many workers understood the importance of holding men accountable, it was acknowledged that plans of service tended to address the actions the mothers must take and were not necessarily focused on what the father was required to do. These barriers or biases of the system were reinforced by practices such as opening the file under the mother's name even if the violence was perpetrated by the father. Within the parameters of their role, workers at the frontline can only do so much to combat this inherent systemic bias that assumes mothers are responsible for the protection of their children. (Brown, Callahan, Strega, Wallmsley & Dominelli, 2009).

While the child protection sector has made significant improvements in working with adult victims of DV, the current study indicated that CPWs need continued training, supervision, and support aimed at increasing skills and confidence in working with perpetrators of DV (Stanley & Humphreys, 2014). For the most part, participants from the current study endorsed the notion that holding men accountable and developing better strategies for engaging fathers was important for the safety of children. This would include routinely opening files under the father's name when the reason for investigation is his violence in the family. These practices are aligned with the exposure reduction and retaliation theories, as reducing exposure and managing risk of perpetrators is necessary in reducing the risk of lethality.

Childhood exposure to DV and risk for lethality requires an enhanced coordinated community response to address the multiple interacting factors that place them at risk (Heise, 1998). While safety planning with the mother and children is important, so too is the risk

management plan for perpetrating fathers. Collaborative community responses for managing perpetrator risk include the involvement of many system stakeholders, such as police, corrections, legal professionals, VAW and CPS. When service involvement is ineffective and lacks the collaborative recognition and management of lethality risk factors, children remain in harm's way. Drawing from the exposure reduction framework, appropriate services are needed for children exposed to domestic violence to keep them safe from the potential of retaliatory violence by the perpetrator (Dugan et al., 2003). To accomplish this safety planning, there is a need for specialized DV training and cross-sectoral collaborative training, to effectively reduce risk and meet the needs of children exposed to domestic violence.

Specialized DV Training

A common theme across all three studies was the importance of specialized DV training. Many workers commented on the lack of specialized training specific to DV, as well as specific training on child risk for lethality or serious harm in cases of DV. They also indicated that the training needed to be earlier in their employment, and provided on an ongoing basis. Training is a critical first step to increasing knowledge and skills and becoming a competent worker (Button & Payne, 2009). Adequate training on the dynamics of DV and the impact on children can inform workers to perform skilled risk assessments and to work with DV cases more collaboratively (Jenney, 2011; Murphy, 2010; Stanley & Humphreys, 2014).

Child protection agencies need to ensure specialized training in DV lethality risk assessment and risk management is available, and that such training is sequenced so that CPWs receive training early in their career. Researchers in the field advocate for training that addresses the complexities of DV and goes beyond the basic dynamics to include curricula on assessing protective and risk factors, the unintended consequences of achieving safety through separation,

deeper understanding of why mothers remain with abusive partners, and the challenges in dealing with DV cases in the child welfare sector (Fleck-Henderson, 2000; Mandel, 2010; Moles, 2008). One exemplary training model on working with DV cases in the child welfare sector is the *Safe and Together Institute* (https://safeandtogetherinstitute.com). This institute delivers child welfare DV training, which provides a framework for partnering with victims and intervening with perpetrators to enhance child safety and well-being. The training provides tools and interventions that support sustainability and integration with local initiatives, mandates and resources.

Managing high-risk cases with multiple risk and protective factors requires specialized knowledge on the complexities of the intersections of many issues. Indeed, participants in study two and three with specialized DV training articulated a more nuanced focus on developing safety plans that included engaging fathers and respecting the autonomy of the non-abusive caregiver. To facilitate child protection procedures that address DV perpetrators behaviours, there is a need to increase child protection workers' knowledge about how best to address these behaviours (Healy & Bell, 2005). Similarly, CPWs also require the skills and willingness to engage with the perpetrators of DV in a change process to ensure the child and mother's safety (Fusco, 2013; Humphreys & Ablser, 2011; Jenney, 2011).

Working Together to Enhance Safety: Importance of Cross-Sector Collaboration

> *"…just being able to name the abuse within a circle of support for that victim, because very often they're not able to do that themselves. But they find that they have tremendous support and that can really increase safety if for example their mother or their neighbour knows."*(Participant from study three)

The importance of collaboration was reiterated throughout this research in the words reflected above by a key informant. Cross-sector collaboration is critical to ensuring information sharing is comprehensive and communicated to address safety concerns (Laing, Heward-Belle, & Toivonen, 2018). Given that the presence of children often increases the number of agencies involved with a family, there is a need for inter-professional, cross-disciplinary collaboration in the risk assessment, risk management, and safety planning for children living in homes where there is DV (Hamilton et al., 2013). Interfacing with professionals in other sectors (i.e., police, VAW sector, corrections) to assess risk provides the opportunity for each to share their knowledge and provide their perspectives on how to mitigate risk. This finding has been repeated throughout the literature and continues to be an area of focus in most promising practice guidelines (Healey, Connolly & Humphreys, 2018; Laing et al., 2018). Several existing strategies and programs aim to counter the structural problems child protection workers face in collaborating with specialized DV services and family law (Macvean, Humphreys & Healey, 2018). However, evaluations of these programs have not met the evidence-based criteria of randomization and robust control groups. Although participants discussed different models and strategies of collaboration within their communities, there was no consistency in using evidence-based practices.

While some workers described their successes with cross-sector collaboration, the process appears to vary across communities and is not without its challenges. Issues in cross-sector collaboration often originate in concerns regarding information sharing and confidentiality, differing core professional models, and orientations towards this work (Frost, Robinson & Anning, 2005; Peckover & Goulding, 2017; Stanley & Humphreys, 2014). System responses to DV can be fragmented in part due to interprofessional differences in understanding

and addressing the problem and opposing mandates (Jaffe, Campbell, Olszowy & Hamilton, 2014; Jaffe et al., 2015; Murphy, 2010; Turner et al., 2015). In part, the child welfare mandate to protect children needs to be recognized by domestic violence advocates, and this validation may help to build alliances to support victims and their children (Mandel, 2010).

Collaborations among service providers are improved when stakeholders use common frameworks, tools, and language (Humphreys, Healey & Mandel, 2018). Establishing policies and protocols with other sectors to outline respective roles in assessing and managing risk helps to facilitate more enduring partnerships to keep families safe (Healey et al., 2018). There are several strategies a community can adapt. While many child protection agencies have established protocols with police to identify risk, the specific processes vary across jurisdictions and may differ depending on the relationships between the sectors (Stanley et al., 2010). Indeed, there is a challenge in sustaining effective partnerships.

One suggestion to achieve effective multi-agency risk assessments is through the development of a common assessment tool that communicates risk across disciplines and with the client (Stanley & Humphreys, 2014). One promising practice identified in the literature and endorsed by participants is the utilization of high-risk case coordination protocols, whereby justice partners and other professionals from multiple sectors meet to discuss individuals identified as high risk, with the goal of coordinating risk management strategies (Department of Justice Canada, 2013). This type of case planning has the ability to focus on the safety and well-being of all victims within the family.

Another avenue to collaboration is through co-location of services. Co-location is a mechanism for embedding specialized skills and knowledge of DV in mandated services (Stanley & Humphreys, 2014). Research has demonstrated that one key outcome of co-location

initiatives and interagency training is *institutional empathy* (Banks, Dutch & Wang, 2008). This institutional empathy brings an understanding of professional and agency difference, allowing for an appreciation of the context shaping the work of a different agency (Banks et al., 2008). A co-located model, such as a family justice centre collaborative model (Gwinn, Strack, Adams & Lovelace, 2007), is one exemplary model of collaboration whereby multiple service providers dealing with DV cases work together under one roof. Moreover, recent revisions to the Ontario child protection training system now includes a two-day domestic violence course that will be jointly facilitated and delivered to CPS and professionals from the DV sector (Ontario Association of Children's Aid Societies, 2019). The expectation is that training the curriculum jointly will ensure a common understanding of risk assessment processes and will encourage community collaborations through relationships developed in the training environment.

Future Research

The nexus of child protection and domestic violence is complicated and requires continued efforts to further understand how to develop effective and sustainable practices. Although this study provided an overview of issues for CPS addressing domestic violence in Ontario, it would be important to examine patterns in other provinces and territories in the context of difference legislation and resources. Even within Ontario, there would be regional differences to explore based on urban versus rural and/or northern counties, which would have less resources and greater challenges serving families. In particular, it would be important to gain the perspectives of CPW serving Indigenous communities and the barriers to developing trusting relationships with families living with domestic violence. Future research could also examine the culturally diverse communities being served in urban centres and some of the unique obstacles intervening in immigrant and refugee families.

Research is needed on the competence and effectiveness of CPS interventions in DV cases via audits on case data and outcomes. The methods in this study (surveys and interviews) are prone to response bias and it is important to determine if child protection workers are doing what they are reporting. Future research can also be focused on the effectiveness of risk assessment tools that support the role of CPS. Further investigation is needed in the evaluation of the tools and determining the validity of these tools in cases involving DV. Risk assessment is not an end in and of itself and it is important to elucidate if the risk assessment tools were helpful in developing safety plans.

Furthermore, there is a critical need to understand the service directions once DV is determined by child protection. With this, policies then can be developed that direct interventions specifically and exclusively to the parent who is perpetrating the abuse. Differential response models in DV cases that have been implemented and studied in Ontario have found that interventions have often focused more broadly on referrals to services for family counselling and improving parenting practices (Alaggia et al., 2013). There is a growing body of literature centred around the idea of developing risk assessment tools based on the different typologies of DV as a means to inform type-specific interventions (Cavanaugh & Gelles, 2005; Lawson, 2019).

Lastly, there were many promising practices identified in this research. Research needs to be undertaken to see if promising translates into effective for children living with domestic violence. Collaboration is central to protecting children and evaluating the work of the overall community response may be as important as the work of any individual agency. Consistent with the risk reduction and retaliation theories, it would be important to see if the interventions offered greater risks or enhanced safety for adult victims and children.

5.3 Limitations

The findings in this dissertation should be considered alongside their limitations. It is important to acknowledge the limitations of the samples across all three studies. Further, the sample was drawn from the child welfare sector in Ontario. Child protection mandates in Canada are determined provincially and as such, each province has different legislation, standards, and tools. The findings of the current study may not be generalizable across Canada and other jurisdictions without a proper analysis of specific standards and legislation related to DV within the child protection mandate. However, drawing from a sample in one province allowed for less complexity when factoring in legislative mandates, standards of practice, and regional differences.

The study did not address the diverse nature of the province and the jurisdictional differences in working with vulnerable populations. Various intersectional identities and associated vulnerabilities of victims and children (e.g., Indigenous populations, immigrants and refugees, families residing in rural, remote and Northern locations) may present additional complexities, and the cumulative effect of these alongside other general risks are not reflected in this research. Some CPWs would be working with more vulnerable victims, such as Indigenous women with a history of colonization and oppression, as a major context in examining DV and the CPS response. Other CPWs may be in larger urban centres, which would face a larger influx of immigrant and refugee families and complex challenges specific to these diverse communities.

Study one utilized secondary data from a retrospective case-based dataset that used homicide reports and interviews to identify the presence of risk factors. This type of data source and research design can be prone to validity issues, such as biases and errors in reporting, due to

the reliance of individual interpretation when coding for the presence of variables. The limited data in case reports is often subject to the researcher's interpretation and may not be an accurate reflection as researchers are forced to draw conclusions. Moreover, there was extremely limited data regarding the details of agency involvement. Domestic homicide is a rare occurrence and the dynamics of this specific phenomenon may not extrapolate to other populations. There were no comparisons drawn to CPS-involved cases that did not end in homicide. There can be no certainty that another intervention by CPS and other community agencies would have changed the course of the homicide.

The samples in studies two and three were self-selected and could have potentially led to the overrepresentation of workers who are well-versed in the area of domestic violence. It was beyond the scope of the data to determine the appropriateness/effectiveness of the actions taken by CPS and other service providers involved with the family (police, VAW, legal professionals). This research did not fully address the complexities of engaging with clients to develop service plans, the specific challenges faced by vulnerable populations, working collaboratively with other sectors, or the risk-related decision-making process involved. The participants were also asked how they act in these cases in general, which did not capture the range of strategies or responses the same worker might employ across cases. Without a comparison group, the research cannot tell us the actual effectiveness of child protection system responses in terms of improving outcomes for those exposed to DV. Additionally, there was a potential for social desirability bias in responses provided by the participants. Nonetheless, the studies provided a variety of knowledge and experience offered by the child protection workers and a clear concern about gaps in service and training in child protection services.

5.4 Final Words

DV continues to be a significant social and public health concern that can have tragic consequences for families. Any death from a domestic homicide has a catastrophic impact. Child protection workers play a critical role in ensuring child safety in families where DV has been reported. Understanding the role they can play in assessing risk and managing risk is important. Child protection workers have to be more prepared and specialized to work collaboratively to support victims and their children, while holding perpetrators accountable in order to maintain safety. This research has demonstrated that the child protection sector cannot do it alone. Enhancing training and collaborative cross sector practices that support front line worker interventions is critical. Continued efforts to improve system responses to DV hold the hope that there will be a significant reduction in domestic homicides.

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Appendices

6.1 Appendix A: Study 1 Ethics Approval

Western Research

Date: 15 May 2018

To: Dr. Peter Jaffe

Project ID: 111577

Study Title: The role of police and service agencies in risk assessment, safety planning and risk management in preventing domestic homicide

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: June 1 2018

Date Approval Issued: 15/May/2018

REB Approval Expiry Date: 15/May/2019

Dear Dr. Peter Jaffe

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Data Summary Form	Other Data Collection Instruments	03/May/2018	

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Western Research

Date: 29 April 2019

To: Dr. Peter Jaffe

Project ID: 111577

Study Title: The role of police and service agencies in risk assessment, safety planning and risk management in preventing domestic homicide

Application Type: Continuing Ethics Review (CER) Form

Review Type: Delegated

Meeting Date: 07/Jun/2019

Date Approval Issued: 29/Apr/2019

REB Approval Expiry Date: 15/May/2020

Dear Dr. Peter Jaffe,

The Western University Non-Medical Research Ethics Board has reviewed this application. This study, including all currently approved documents, has been re-approved until the expiry date noted above.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Daniel Wyzynski, Research Ethics Coordinator, on behalf of Prof. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

6.2 Appendix B: DVDRC Risk Factor Coding Form

Domestic Violence Death Review Committee Office of the Chief Coroner of Ontario
Risk Factor Coding Form (see descriptors below)

A= Evidence suggests that the risk factor was not present
P= Evidence suggests that the risk factor was present
Unknown (Unk) = A lack of evidence suggests that a judgment cannot be made

Risk Factor Descriptions (updated 2015)

Perpetrator = The primary aggressor in the relationship

Victim = The primary target of the perpetrator's abusive/maltreating/violent actions

Perpetrator History

	Perpetrator History	**Definition**
1	Perpetrator was abused and/or witnessed DV as a child	As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
2	Perpetrator exposed to/witnessed suicidal behavior in family of origin	As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.

Family/Economic Status

	Family/Economic Status	**Definition**
3	Youth of couple	Victim and perpetrator were between the ages of 15 and 24.
4	Age disparity of couple	Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.
5	Victim and perpetrator living common-law	The victim and perpetrator were cohabiting.
6	Actual or pending separation	The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.

Family/Economic Status

	Family/Economic Status	**Definition**
7	New partner in victim's life	There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life
8	Child custody or access disputes	Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.
9	Presence of step children in the home	Any child(ren) that is(are) not biologically related to the perpetrator.
10	Perpetrator unemployed	Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.

Perpetrator Mental Health

	Perpetrator Mental Health	**Definition**
11	Excessive alcohol and/or drug use by perpetrator	Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.

Perpetrator Mental Health

	Perpetrator Mental Health	**Definition**
12	Depression – in the opinion of family/friend/acquaintance	In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.
13	Depression – professionally diagnosed	A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.
14	Other mental health or psychiatric problems – perpetrator	For example: psychosis; schizophrenia; bi-polar disorder; mania; obsessive-compulsive disorder, etc.
15	Prior threats to commit suicide by perpetrator	Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.
16	Prior suicide attempts by perpetrator	Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.

Perpetrator Attitude/Harassment/Violence

	Perpetrator Attitude/ Harassment/ Violence	**Definition**
17	Obsessive behavior displayed by perpetrator	Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
18	Failure to comply with authority	The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or "No Contact" orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.
19	Sexual jealousy	The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.
20	Misogynistic attitudes – perpetrator	Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements, or can be more subtle with beliefs that women are only good for domestic work or that all women are "whores."
21	Prior destruction or deprivation of victim's property	Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
22	History of violence outside of the family by perpetrator	Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).

Perpetrator Attitude/Harassment/Violence

	Perpetrator Attitude/ Harassment/ Violence	**Definition**
23	History of domestic violence - **Previous** partners	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person **who has been in** an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
24	History of domestic violence - **Current** partner/victim	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who **is in an** intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
25	Prior threats to kill victim	Any comment made to the victim, or others, that was intended to instill fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from "I'm going to kill you" to "You're going to pay for what you did" or "If I can't have you, then nobody can" or "I'm going to get you."

Perpetrator Attitude/Harassment/Violence

	Perpetrator Attitude/ Harassment/ Violence	**Definition**
26	Prior threats with a weapon	Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g, "I'm going to shoot you" or "I'm going to run you over with my car") or implicit (e.g., brandished a knife at the victim or commented "I bought a gun today"). Note: This item is separate from threats using body parts (e.g., raising a fist).
27	Prior assault with a weapon	Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).
28	Prior attempts to isolate the victim	Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., "if you leave, then don't even think about coming back" or "I never like it when your parents come over" or "I'm leaving if you invite your friends here").
29	Controlled most or all of victim's daily activities	Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).

Perpetrator Attitude/Harassment/Violence

	Perpetrator Attitude/ Harassment/ Violence	**Definition**
30	Prior hostage-taking and/or forcible confinement	Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).
31	Prior forced sexual acts and/or assaults during sex	Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.
32	Choked/strangled victim in past	Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).
33	Prior violence against family pets	Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
34	Prior assault on victim while pregnant	Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.

Perpetrator Attitude/Harassment/Violence

	Perpetrator Attitude/ Harassment/ Violence	**Definition**
35	Escalation of violence	The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.
36	Perpetrator threatened and/or harmed children	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) towards children in the family. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family; friends; neighbours; co-workers; counselors; medical personnel, etc).
37	Extreme minimization and/or denial of spousal assault history:	At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).

Access

	Access	**Definition**
38	Access to or possession of any firearms	The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.

Access

	Access	**Definition**
39	After risk assessment, perpetrator had access to victim	After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.

Victim Disposition

	Victim's Disposition	**Definition**
40	Victim’s intuitive sense of fear of perpetrator	The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, “I fear for my life”, “I think he will hurt me”, “I need to protect my children”, this is a definite indication of serious risk.

6.3 Appendix C: DVDRC Data Summary Form

OCC Case #(s):
OCC Region: Central
OCC Staff: _____
Lead Investigating Police Agency:
Officer(s):
Other Investigating Agencies: _
Officers: __
VICTIM INFORMATION
***If more than one victim, this information is for primary victim (i.e. intimate partner)*

Gender	
Age	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	
Residency status	
Education	
Employment status	
Occupational level	
Criminal history	
If yes, check those that apply...	____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation ____ Prior arrest record for other assault/harassment/menacing/disturbance ____ Prior arrest record for DUI/possession ____ Juvenile record

____ Total # of arrests for domestic violence offenses ____ Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history
If yes, check those that apply... ____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history

If yes, check those that apply... ____ Prior domestic violence treatment ____ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management ____ Other – specify _____ ____ No info

Victim taking medication at time of incident	
Medication prescribed for victim at time of incident	
Victim taking psychiatric drugs at time of incident	
Victim made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or Adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

-- END VICTIM INFORMATION --

PERPETRATOR INFORMATION

***Same data as above for victim*

Gender	
Age	
Marital status	
Number of children	
Pregnant	
If yes, age of fetus (in weeks)	
Residency status	
Education	
Employment status	
Occupational level	
Criminal history	

If yes, check those that apply... ____ Prior domestic violence arrest record ____ Arrest for a restraining order violation ____ Arrest for violation of probation

____ Prior arrest record for other assault/harassment/menacing/disturbance ____ Prior arrest record for DUI/possession ____ Juvenile record
____ Total # of arrests for domestic violence offenses ____Total # of arrests for other violent offenses ____ Total # of arrests for non-violent offenses ____ Total # of restraining order violations ____ Total # of bail condition violations ____ Total # of probation violations
Family court history
If yes, check those that apply... ____ Current child custody/access dispute ____ Prior child custody/access dispute ____ Current child protection hearing ____ Prior child protection hearing ____ No info
Treatment history
If yes, check those that apply... ____ Prior domestic violence treatment ____ Prior substance abuse treatment ____ Prior mental health treatment ____ Anger management ____ Other – specify _____ ____ No info

Perpetrator on medication at time of incident	
Medication prescribed for perpetrator at time of incident	
Perpetrator taking psychiatric drugs at time of incident	
Perpetrator made threats or attempted suicide prior to incident	
Any significant life changes occurred prior to fatality?	
Describe:	
Subject in childhood or Adolescence to sexual abuse?	
Subject in childhood or adolescence to physical abuse?	
Exposed in childhood or adolescence to domestic violence?	

INCIDENT

-- END PERPETRATOR INFORMATION --

Date of incident	
Date call received	
Time call received	
Incident type	
Incident reported by	

Total number of victims ***Not including perpetrator if suicided*	
Who were additional victims aside from perpetrator?	
Others received non-fatal injuries	
Perpetrator injured during incident?	
Who injured perpetrator?	

Location of crime

Location of incident	
If residence, type of dwelling	
If residence, where was victim found?	

Cause of Death (Primary Victim)

Cause of death	
Multiple methods used?	
If yes be specific ...	
Other evidence of excessive violence?	
Evidence of mutilation?	
Victim sexually assaulted?	
If yes, describe (Sexual assault, sexual mutilation, both)	
Condition of body	
Victim substance use at time of crime?	
Perpetrator substance use at time of crime?	

Weapon Use

Weapon use	
If weapon used, type	
If gun, who owned it?	
Gun acquired legally?	
If yes, when acquired?	
Previous requests for gun to be surrendered/destroyed?	
Did court ever order gun to be surrendered/destroyed?	

Witness Information

Others present at scene of fatality (i.e. witnesses)?	
If children were present:	
What intervention occurred as a result?	

Perpetrator actions after fatality

Did perpetrator attempt/commit suicide following the incident?	
If committed suicide, how?	
Did suicide appear to be part of original homicide?	
How long after the killing did suicide occur?	

Was perpetrator in custody when attempted or committed suicide?	
Was a suicide note left? *If yes, was precipitating factor identified*	
Describe: *Perpetrator left note attached to envelope and within the envelope were photos of the victim and her boyfriend and correspondence regarding the purchase of a house in North Dakota and money transfers etc.*	
If perpetrator did not commit suicide, did s/he leave scene?	
If perpetrator did not commit suicide, *(At scene, turned self in, apprehended later, still at large,* where was s/he *other – specify)* arrested/apprehended?	
How much time passed between the *(Hours, days, weeks, months, unknown, n/a – still at large)* fatality and the arrest of the suspect:	

-- END INCIDENT INFORMATION -- VICTIM/PERPETRATOR RELATIONSHIP HISTORY

Relationship of victim to perpetrator	
Length of relationship	
If divorced, how long?	
If separated, how long?	
If separated more than a Month, list # of months	
Did victim begin relationship with a new partner?	
If not separated, was there evidence that a separation was imminent?	
Is there a history of separation in relationship?	
If yes, how many previous (Indicate #, unknown separations were there?	
If not separated, had victim tried to leave relationship	
If yes, what steps had victim taken in past year to leave relationship? (Check all that apply) ____ Moved out of residence ____ Initiated defendant moving out ____ Sought safe housing ____ Initiated legal action ____ Other – specify	

Children Information

Did victim/perpetrator have children in common?	
If yes, how many children in common?	
If separated, who had legal custody of children?	
If separated, who had physical custody of children at time of incident?	

Which of the following best describes custody agreement?	
Did victim have children from previous relationship?	
If yes, how many? (Indicate #)	

History of domestic violence

Were there prior reports of domestic violence in this relationship?

Type of Violence? *(Physical, other)*

_____

If other describe: _____

_____

_____

If yes, reports were made to: (Check all those that apply)

____ Police
____ Courts
____ Medical
____ Family members
____ Clergy
____ Friends
____ Co-workers
____ Neighbors
____ Shelter/other domestic violence program
____ Family court (during divorce, custody, restraining order proceedings)
____ Social services
____ Child protection
____ Legal counsel/legal services
____ Other – specify _____

Historically, was the victim usually the perpetrator of abuse? _____

If yes, how known? _____

Describe: _____

_____

_____

Was there evidence of escalating violence?

If yes, check all that apply:

____ Prior attempts or threats of suicide by perpetrator
____ Prior threats with weapon
____ Prior threats to kill
____ Perpetrator abused the victim in public
__ __ Perpetrator monitored victim's whereabouts
____ Blamed victim for abuse
____ Destroyed victim's property and/or pets
____ Prior medical treatment for domestic violence related injuries reported
____ Other – specify _____

-- END VICTIM-PERPETRATOR RELATIONSHIP INFORMATION --

SYSTEM CONTACTS

Background

Did victim have access to working telephone? _____

Estimate distance victim had to travel to access helping resources? (KMs)

_____

Did the victim have access to transportation? _____

Did the victim have a Safety Plan? _____

Did the victim have an opportunity to act on the Plan? _____

Agencies/Institutions

Were any of the following agencies involved with the victim or the perpetrator during the past year prior to the fatality? _____

***Indicate who had contact, describe contact and outcome. Locate date(s) of contact on events calendar for year prior to killing (12-month calendar)*

Criminal Justice/Legal Assistance:

Police (Victim, perpetrator, or both)

Describe:_____

_____

Outcome:_____

Crown attorney (Victim, perpetrator, or both)

Describe:_____

_____

Outcome:_____

Defense counsel (Victim, perpetrator, or both)

Describe:_____

_____

Outcome:_____

Court/Judges (Victim, perpetrator, or both)

Describe:_____

_____

Outcome:_____

Corrections (Victim, perpetrator or both)

Describe:_____

_____

Outcome:_____

Probation (Victim, perpetrator, or both)

Describe:_____

_____

Outcome:_____

Parole (Victim, perpetrator, or both)

Describe:_____

_____

Outcome:_____

Family court (Victim, perpetrator, or both)

Describe:_____

_____

Outcome:_____

Family lawyer (Victim, perpetrator, or both)

Describe_____

_____
Outcome:_____
Court-based legal advocacy (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Victim-witness assistance program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Victim Services (including domestic violence services)
Domestic violence shelter/safe house (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Sexual assault program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Other domestic violence victim services (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Community based legal advocacy (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Children services
School (Victim, perpetrator, children or all)
Describe: (Did school know of DV? Did school provide counseling?)
_____
_____
Outcome:_____
Supervised visitation/drop off center (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Child protection services (Victim, perpetrator, children, or all)
Describe:_____
_____
Outcome:_____
Health care services
Mental health provider (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____

Mental health program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Health care provider (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
_____
Outcome:_____
Local hospital (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Ambulance services (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Other Community Services
Anger management program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Batterer's intervention program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Marriage counselling (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Substance abuse program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Religious community (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Immigrant advocacy program (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Animal control/humane society (Victim, perpetrator, or both)
Describe:_____

_____
Outcome:_____
Cultural organization (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Fire department (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
Homeless shelter (Victim, perpetrator, or both)
Describe:_____
_____
Outcome:_____
-- END SYSTEM CONTACT INFORMATION --
RISK ASSESSMENT
Was a risk assessment done?
*If yes, by whom?*_____
When was the risk assessment done?_____
What was the outcome of the risk assessment?_____
DVDRC COMMITTEE RECOMMENDATIONS
Was the homicide (suicide) preventable in retrospect? (Yes, no)
If yes, what would have prevented this tragedy?
_____
_____
_____
_____
_____
_____
_____
What issues are raised by this tragedy that should be outlined in the DVDRC annual report?
_____
_____
_____
_____
_____
_____
_____
_____
_____
Future Research Issues/Questions:
_____
_____
_____

_____
_____
_____

Additional comments:

_____
_____
_____
_____
_____

6.4 Appendix D: Key Informant Interview Documents

CDHPIVP Interview Guide

Name of interviewer: _____

Participant Code_____

Date of interview: _____

Section A.

Hello. My name is_____.

Thank you for agreeing to participate in this research interview regarding domestic violence risk assessment, risk management and safety planning. This interview is being conducted as part of the Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations. The Co-Directors are Dr. Peter Jaffe and Dr. Myrna Dawson, and the Co-Investigator for this region is _____ (e.g. Dr. Mary Hampton for Saskatchewan).

This interview asks about your knowledge and use of risk assessment, risk management, and safety planning strategies and tools, focusing on four populations identified as experiencing increased vulnerability for domestic homicide: Indigenous, immigrants and refugees, rural, remote, and northern populations, and children exposed to domestic violence. I will be asking you about risk factors, barriers to effective risk management and safety planning, and strategies currently being used with these vulnerable groups and the communities in which they live. Some questions I will ask may have you focus on specific cases you have dealt with in your work and may trigger emotional responses.

Because the topic of domestic violence and domestic homicide may be distressing and depending on your personal experiences in the work these questions may trigger some memories of cases you have worked with that were violent or upsetting, I am obliged to discuss vicarious trauma with you. If the questions in the interview cause you to become distressed, do you have someone you can reach out to, either in your workplace, or through an EAP program, or elsewhere?
If the person replies no, "Are you aware of resources in your community or other communities that you can reach to either by phone or in person?"
I can follow up with a link to a list of support lines that I will email to you after the interview. (include link www.yourlifecounts.org)

Before we begin, I want to make sure we've walked through the informed consent and that you have had an opportunity to have any questions addressed.

If Interview is by phone or Skype:
Have you received and read the Information Letter and Consent form for Interview? (Circle Response) YES NO
If yes, have you signed and returned the consent form to [redacted]?
Do you have any questions at this time?

If no,
I would like to take a moment to review the consent form with you.
Prompt: Review the consent to participate in research form.

"Do you agree to participate in this research?" Verbal consent should explicitly state that they have read the Letter of Information and agree to participate. Note: Obtain their consent verbally if they have not sent the email so you can get on with the interview without delay

Note: the participant will still need to send an email to [redacted] which states, "I have read and understood the letter of information and agree to participate in this interview."

Along with the informed consent, we sent you our definitions of risk assessment, risk management, and safety planning to review. Do you happen to have the definitions in front of you as we will ask for feedback later in the interview? YES NO
If yes, go to obtaining permission to audio record the interview.

If no, I can email the definitions to you again but I will also read out the definition when we get to the corresponding questions in order to get your feedback.

With your permission, I am going to audio record this interview for transcription purposes only. The audio recording will be destroyed at the end of the study.
Do I have your permission to record this interview? YES NO.
If yes, turn on recorder. Thank you.

If no, will it be possible to reschedule this interview? If the interview is not recorded, we require two research assistants to be present so one person can conduct the interview and the other person can take notes to ensure accuracy. YES NO

This interview will take about 45 minutes to an hour to complete. You are free to withdraw from the interview at any time. If we run out of time, and you wish to complete the interview, do I have your permission to contact you at a later date to complete the interview?
(Circle response) YES NO

Thank you.

If interview is in person:

Have you received and read the Information Letter and Consent form for Interview? (Circle Response) YES NO
If yes, have you signed and returned the consent form to Anna-Lee Straatman or do you have it with you now?
Do you have any questions at this time?

If no,
I would like to take a moment to review the consent form with you.
Prompt: Review the consent to participate in research form.

If you are in agreement with this, please sign.

Along with the informed consent, we sent you our definitions of risk assessment, risk management, and safety planning to review. Do you happen to have the definitions in front of you as we will ask for feedback later in the interview? YES NO
If yes, go to obtaining permission to audio record the interview.

If no, I can provide the definitions to you again but I will also read out the definition when we get to the corresponding questions in order to get your feedback.

With your permission, I am going to audio record this interview for transcription purposes only. The audio recording will be destroyed at the end of the study.
Do I have your permission to record this interview? YES NO.
If yes, turn on recorder. Thank you.

If no, will it be possible to reschedule this interview? If the interview is not recorded, we require two research assistants to be present so one person can conduct the interview and the other person can take notes to ensure accuracy. YES NO

This interview will take about 45 minutes to an hour to complete. You are free to withdraw from the interview at any time. If we run out of time, and you wish to complete the interview, do I have your permission to contact you at a later date to complete the interview?
(Circle response) YES NO

Thank you.

Section B.

Now I would like to ask you a few questions about where you work and the kind of work you do.

1. Where is your agency located (clarify name of town, city, etc and province)? Please note the name of your agency will not be identified in any reports or publications.

_____

2. Which sector do you work in? (e.g., VAW, family law, police, victim services, health, education, settlement services)

   _____
   _____

3. What is your job title? (Note: do not record job title if it can identify the participant – e.g., Executive Director of an agency in a small community)

   _____

4. What does your role as [job title] entail? _____
5. How much of your work /percentage of clients involves direct contact with victims or perpetrators of dv?
6. How long has it been that you have recognized that the concerns of victims and perpetrators are a part of your role? _____

Risk Assessment

I'm now going to ask you some questions about risk assessment.

Risk assessment involves evaluating the level of risk a victim of domestic violence may be facing, including the likelihood of repeated or lethal violence. It may be based on a professional's judgment based on their experience in the field and/or a structured interview and/or an assessment tool/instrument that may include a checklist of risk factors.

7. Do you have any feedback on this definition of risk assessment? For example, is this a definition that you would use in the context of your work?

8. In your role at (see response to Q#3) _____, do you conduct risk assessments as we described? YES NO

If no, who does (e.g., referral to another organization, frontline professionals in the organization)? _____

If yes…

a) Do you use your professional judgment in risk assessment? YES NO
   Please explain. _____
b) Do you use a structured interview? YES NO
   If yes, please describe the structured interview. _____
c) Do you use a structured tool/instrument? YES NO
   If yes, what tool(s) do you use? _____
d) Did you receive training on this tool(s)? YES NO
   If yes, who conducted the training? _____
   How many trainings did you receive? (e.g., refresher training)
   _____

9. Is conducting a risk assessment mandatory or optional in your organization/role? (e.g. only done when charges are laid)

   _____

10. If someone is deemed to be high risk, what happens next in terms of information sharing and interventions?

    _____

11. Are there any written documents/directives (e.g., policies, protocols) that guide risk assessment within your organization? YES NO

Please elaborate: _____

12. Are the victim's perceptions of safety considered in the risk assessment? YES NO
Please elaborate: _____

13. If children are present, is there an automatic referral to child protection? (do they get involved or just file report) YES NO Skip question if interviewing a child protection worker.
Please elaborate: _____

14. Are children included in the risk assessment? YES NO
Please elaborate: _____

15. Do you collaborate with other organizations when assessing risk? YES NO
If yes, which ones? _____

Risk Management
I'm now going to ask you some questions about risk management.

Risk management refers to strategies to reduce the risk presented by a perpetrator of domestic violence such as close monitoring or supervision and/or counselling to address the violence and/or related mental health or substance use problems.

16. Do you have any feedback on this definition of risk management? For example, is this a definition that you would use in the context of your work?
17. In your role at (see response to Q#3) _____, do you engage in risk management strategies? YES NO
If no, who does (e.g., referral to another person in agency or another agency)?

If yes…
a) What are the strategies you use? _____
b) Did you receive training in risk management? YES NO Can you tell me about the training you've received regarding risk management?
If yes, who conducted the training? _____
If yes, how many trainings did you receive? (e.g., refresher training)
_____

18. Are children included/considered in the risk management strategy? YES NO
If yes, please elaborate: _____
19. Are there any written documents/directives (e.g., policies, protocols) that guide risk management within your organization? YES NO
Please elaborate: _____

20. Do you collaborate with other organizations regarding risk management? YES NO
If yes, which ones? _____

Safety Planning
I'm now going to ask you some questions about safety planning.

Safety planning identifies strategies to protect the victim. Strategies may include: educating victims about their level of risk; changing residence, an alarm for a higher priority police response, a different work arrangement and/or readily accessible items needed to leave the home in an emergency including contact information about local domestic violence resources.

21. Do you have any feedback on our definition of safety planning? For example, is this a definition that you would use in the context of your work?

22. In your role at [see response to Q#3], do you provide safety plans for victims? YES NO Please elaborate: _____

    If no, who does so (e.g., referral to another agency, frontline professionals in the organization)? _____

If yes…

a) What are the strategies you use?_____
b) Did you receive training on safety planning? YES NO
   If yes, who conducted the training? _____
   How many trainings did you receive? (e.g., refresher training)
   _____

23. Are there any written documents/directives (e.g., policies, protocols) that guide safety planning within your organization? YES NO
    Please elaborate: _____

24. Are children included in the safety plan? YES NO
    Please elaborate: _____

25. Do you collaborate with other organizations around safety planning? YES NO
    a. If yes, which ones? _____

Unique Challenges for Vulnerable Populations

26. Do you work with individuals who fit into one or more of the following groups? (name them and check all that person says yes to)
    b. Indigenous people
    c. immigrants and refugees
    d. rural, northern and remote communities
    e. children exposed to domestic violence

    i. If yes, how do you become involved with these clients? (e.g. referral; community outreach; voluntary; mandatory)
    _____

[Note to interviewer: For each vulnerable population identified in question 26 ask the following questions. If none identified, skip to question 28.

27. You indicated that you work with (name all that apply):
    - Indigenous people
    - immigrants and refugees
    - rural, northern and remote communities
    - children exposed to domestic violence

[Note to interviewer – for each of the follow up questions, prompt participant to address the population(s) they have the most experience with and then address the others if there is more time – when discussing multiple populations some answers may overlap, some will be different.]

a) What are the challenges dealing with domestic violence within these particular populations? _____

b) What are some unique risk factors for lethality among these populations? _____

c) What are some helpful promising practices? (Including specific risk assessment tools, risk management and safety planning strategies that address vulnerabilities.) _____

28. That is the end of the interview questions. Do you have any other comments you would like to make? If yes: _____

29. Thank you very much for participating in this interview. Your answers have been very helpful.

30. We talked at the beginning of this interview about the possibility of vicarious trauma, related to answering these questions, that talking about your experience with risk assessment and risk management with individuals experiencing violence may be triggering for you. Do you have peers, supervisors or counsellors you can speak to? Would you like me to send you some information about helplines to reach out to?

31. If you are interested in learning more about this project, updates are available on the project website at www.cdhpi.ca

If you have any questions about the study, please contact Dr. Jaffe or Dr. Dawson.

[NOTE: If the participant asks how the results from this study will be used, please inform the participant that findings from this study will be shared through brief reports available on our website www.cdhpi.ca; academic and scholarly publications; and at our upcoming conference in October (information on the conference is available on our website). Assure the participant that at no time will their name or identifying information be revealed.]

32. Would you permit us to email you our findings, resources, and publications that resulted from this study?

33. Do you know of a colleague or someone else who may be interested in being interviewed for this study?

[*NOTE*: If they identify someone, please ask if they would be willing to email that person, with a CC to you, with details of the research study and scheduling an interview OR if they could provide the person's contact information so you can email them directly.]

Send a follow-up email to the participant about one week after completion of the interview.

Message:

> *Thank you very much for participating in this interview. Your answers have been very helpful. More information about this research study is available on our website at www.cdhpi.ca*

6.5 Appendix E. Key Informant Consent

CONSENT TO PARTICIPATE IN RESEARCH

Date:_____

Thank you for your interest in participating in the Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations (CDHPIVP) Research Project (Project No.108312). This project is led by Dr. Myrna Dawson, Director of the Centre for Social and Legal Responses to Violence, University of Guelph and Dr. Peter Jaffe, Director of the Centre for Research and Education on Violence Against Women and Children, Western University, and is funded by the Social Sciences and Humanities Research Council of Canada.

If you have any questions or concerns about the research, please feel free to contact Dr. Dawson [redacted] Dr. Jaffe at [redacted]

This project involves asking about your knowledge and use of risk assessment, risk management, and safety planning strategies and tools, focusing on four populations identified as experiencing increased vulnerability for domestic homicide: Indigenous, immigrants and refugees, rural, remote, and northern populations, and children exposed to domestic violence. We will be asking you about potentially unique risk factors, barriers to effective risk management and safety planning, and strategies currently being used with these vulnerable groups and the communities in which they live.

POTENTIAL RISKS AND DISCOMFORTS

Confidentiality: Information gathered from this interview may be used in report summaries and future publications. This may include quotations from interviews, with any identifying information (name, agency, organization, province/territory) removed. No individual, agency, or organization that participates in an interview will be named in any reports or applications unless permission is received beforehand to do so, and every effort will be made to exclude identifying information about an individual, agency, or organization in report summaries and future publications. Therefore, the risk of participating in this interview is minimal.

Emotional distress: While you are not likely to encounter any additional risks participating in this study than you would in the context of your day-to-day work, it is important to note that certain topics or questions may be upsetting or stressful to different people, and we will be asking you about domestic violence and domestic homicide cases of which you may be aware. We will make every effort to have appropriate resources and supports on hand or easily accessible. Upon request participants may be given a list of general interview questions ahead of time so they will be prepared for the nature and scope of questions that we will be asking.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Your participation in this research has the potential to provide several benefits for those experiencing domestic violence, the community of individuals and sectors who provide services and resources to these individuals, to scientific community, and society in general. In short, it will begin to provide a mechanism through which we can more clearly understand the types of risk assessment, risk management, and safety planning available populations identified as experiencing increased risk of domestic homicide.

PAYMENT FOR PARTICIPATION

Individual participants will not be compensated for the time it takes to complete this survey.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study.

Information from interviews will be presented without names, organizations, or other identifying information in final reports and future publications. Only research assistants and their supervisors will have access to your identified interview data, and they will be required to sign a confidentiality agreement. Research assistant supervisors include faculty from Western University, University of Guelph, Saint Mary's University, Université du Québec à Montréal, University of Manitoba, Native Women's Association of Canada, University of Regina, University of Calgary, and Simon Fraser University. Interview recordings and transcripts will be retained until six months after completion of the project (June 30, 2021) and after that will be destroyed.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. You will be audio recorded only if you give permission for us to do so. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind before or during the interview without explanation. You also have the right to withdraw your participation at any point before the end of the data collection on August 31, 2017. You may also refuse to answer any questions you do not want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise that warrant doing so.

Should you withdraw your participation entirely you may decide at that time if we may use any of the information you have provided. If you do not want us to use the interview material, we will destroy the notes and/or any audio recording material and they will not be used in the final research report or future publications.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board, the Western University Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Director, Research Ethics
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone [redacted]
E-mail: [redacted]
Fax: ([redacted]

OR

Director, Research Ethics
Western University
Room 5150
Support Services Building
London, ON N6G 1G9

Telephone: [redacted]
E-mail: [redacted]
Fax [redacted]

Having read and understood the above letter, and being satisfied with the answers to any questions I have asked, I consent to participate in this research study:

Name: _____ Date:_____

I consent to being audio recorded during this interview:

Name: _____ Date:_____

I consent to having portions of my responses included as quotations in the final research report and future publications, with identifying information removed:

Name: _____ Date:_____

Witness: _____ Date:_____

PLEASE EMAIL THE SIGNED CONSENT TO [redacted] AT [redacted] OR FAX TO [redacted]

Curriculum Vitae

Name: Laura Olszowy

Post-secondary Education and Degrees:

Western University
London, Ontario, Canada
2016-2020 (expected) Ph.D., School and Applied Child Psychology

Western University
London, Ontario, Canada
2014-2016 (expected) M.A., Counselling Psychology

Western University
London, Ontario, Canada
2006-2011 B.A., Honors Specialization Psychology, Major Sociocultural Anthropology

Honours and Awards:

Social Science and Humanities Research Council, Joseph A. Bombardier Canada Graduate Scholarship, Doctoral
2018-2021

The David Wolfe Scholarship on Research in Violence Prevention
2017

Scotiabank Graduate Award for Studies in Violence Against Women and Children
2015

Western Graduate Research Scholarship
2015

Social Science and Humanities Research Council, Joseph A. Bombardier Canada Graduate Scholarship, Master's
2015-2016

Western Graduate Research Scholarship
2014

Dean's Honour List, Faculty of Social Science
2006/2007, 2007/2008, 2009/2010, 2010/2011

Western Scholarship of Excellence
2006

Related Work Experience:

Psychology Resident
London Family Court Clinic
2019-2020

Student Clinician
Child and Youth Development Clinic
2018-2019

Teaching Assistant, EDU 5019 – Safe Schools
Western University, Faculty of Education
2018-2019

Psychometrist, Psychological Services
Thames Valley District School Board
2017, 2018

Practicum Student, Mary J. Wright Centre
Merrymount Family Support and Crisis Centre
2017

Research Assistant
Canadian Domestic Homicide Prevention Initiative
2016-2020

Student Intern/Practicum Student, Psychological Services
Thames Valley District School Board
2015-2016, 2017-2018

Volunteer Co-facilitator, FASD 'A Night Out' Caregiver Support
London Family Court Clinic
2015-2016, 2019-2020

Research Assistant, DV@WorkNet
Centre for Research and Education on Violence Against Women and Children
2014-2016

Residential Counsellor
Western Area Youth Services
2012-2014

Residential Counsellor
Women's Rural Resource Centre
2011-2014

Volunteer Co-facilitator, Community Group Program for Children Exposed to Woman Abuse
2011-2012
Research Assistant –Dr. Kathryn Graham
Social and Epidemiological Research Department. Centre for Addiction and Mental Health
2009-2010

Research Assistant – Dr. Peter Jaffe
Centre for Research and Education on Violence Against Women and Children
2009

Publications

MacQuarrie, B. J., Scott, K., Lim, D., Olszowy, L., Saxton, M., MacGregor, J. C. D., & Wathen, C. N. (2019). Understanding domestic violence as a workplace problem. In R.J. Burke & A.M. Richardsen (Eds.) *Increasing Occupational Health and Safety in Workplaces.* United Kingdom: Edward Elgar Publishing.

Saxton, M., Olszowy, L., MacGregor, J. C. D., MacQuarrie, B. J. & Wathen, C. N. (2018). Experiences of intimate partner violence victims with police and the justice system in Canada. *Journal of Interpersonal Violence.*

MacGregor, J. C. D., Wathen, C. N., Olszowy, L., Saxton, M., & MacQuarrie, B. J. (2016). Workplace disclosure and supports for domestic violence: Results of a pan-Canadian survey. *Violence and Victims.*

Jaffe, P.G. Campbell, M., Olszowy, L.P. & Hamilton, L.A.H. (2014). Paternal filicide in the context of domestic violence: Challenges in risk assessment & risk management for community and justice professionals. *Child Abuse Review, 23*(2)*:*142-153.

Olszowy, L., Jaffe, P.G., Campbell, M., & Hamilton, L.A.H. (2013). Effectiveness of risk assessment tools in differentiating child homicides from other domestic homicide cases. *Journal of Child Custody, 10*(2), 185-206.

Jaffe, P.G., Campbell, M., & Olszowy, L.P. (2013). Health care professionals' role in preventing child homicides in the context of domestic violence. *Paediatrics Today, 9*(1), 55-63.